Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING _____ B. WING _____	01/08/2010

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) COMPLETE DATE
L 000	Initial Comments An annual licensure survey was conducted on January 5 through 8, 2010. Complaint #DC00001920/09-022 was also investigated during this survey. The following deficiencies were based on observation, record review, staff and resident interviews. The sample included 26 residents based on a census of 169 residents on the first day of survey and three (3) supplemental residents.	L 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.	
L 008	3202.2 Nursing Facilities Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease. This Statute is not met as evidenced by: Based on staff interview and a review of one (1) of five (5) newly hired employee records, it was determined that facility staff failed to obtain a chest x-ray to determine the presence or absence of communicable disease. The findings include: According to 22 DCMR 3202.2, "Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease." According to the Selection and Hiring Procedures, Policy No: HR TMP005-02", "...Successful completion of a...PPD or Chest X-ray prior to the first day of employment..." The Newly Hired Employee #4 was hired on November 30, 2009.	L 008	1. **Corrective Action(s)** No employee or resident was affected by the oversight. The employee in question presented Human Resources with a valid chest x-ray on January 6, 2010. 2. **Identification of Deficient Practices & Corrective Actions** The personnel files of new hires over the last 3 orientations were audited and found to be in compliance; all health records were negative for communicable disease. TWH's pre-employment process will uphold the standards and requirements of the Selection and Hiring Procedures policy by ensuring that all newly hired employees will have successfully completed a PPD or chest x-ray prior to his/her first day of employment.	

Health Regulation Administration

Dawn Alley Williamson LCHA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X8) DATE: 2/26/10

Health Regulation Administration

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L 008	Continued From page 1 A review of the "Employee Screen for Tuberculosis" dated December 15, 2009 revealed that the Newly Hired Employee #4 answered yes to the following questions: "Were you ever informed that you tested positive for Tuberculosis? [And] have you ever had a chest X-ray suggestive of Tuberculosis?" Additionally, the employee was referred to the local health department for further screening before work can be resumed on December 22, 2009. There was no evidence in the record that the above cited employee had a chest x-ray on his/her personnel record to verify the presence or absence of communicable disease prior to the date of hire and after the referral on December 22, 2009. A face-to-face interview was conducted with Employee #12 on January 6, 2009 at approximately 3:30 PM. He/she stated, "The employee has worked since November 30, 2009 and was sent home today." He/she acknowledged that there was no chest x-ray on the employee record to determine the presence or absence of communicable disease.	L 008	**3. Systemic Changes** The offer letter to new hires will emphasize compliance with the standard as a condition of accepting employment and reporting for orientation; HR staff was reminded of the health requirement standard during the pre-employment process. If a newly hired employee fails to have his/her PPD or chest x-ray available on their first day of employment, they will not be able to attend orientation or begin working. **4. Monitoring** Report compliance with health requirement bi-monthly to Safety/QI committee. **5. Compliance Date** 2/22/2010	Bi-monthly
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:	L 052		

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L 052	Continued From page 2 (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j) Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: 1. Based on observations, record review and interview for three (3) of 26 sampled residents, it was determined that facility staff failed to: obtain ophthalmology services, apply a chair monitor	L 052		

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L 052	Continued From page 3 and assess the apical pulse prior to the administration of an antiarrhythmic medication for one (1) resident, obtain vital signs for one (1) resident and fill the oxygen humidifier with water for one (1) resident. Residents #3, 15 and 20. The findings include: A.1.The charge nurse failed to schedule a follow-up appointment for Resident #3 The findings include: A review of the clinical record revealed a "Complete Eye Examination "completed on November 14, 2008. The examination revealed the following documentation, "Poor vision in right eye is from foveal lesion, dry atrophic macular degeneration." "Advice/recommendation: Follow-up as need, or in 1 year." A face-to- face interview was conducted with Employee #5 at approximately 12:00 Noon on January 5, 2010. He/She acknowledged that an ophthalmology follow-up appointment was not schedule. The record was reviewed on January 5, 2010. A. 2. The charge nurse failed to apply chair alarm as ordered by Physician for Resident #3 The findings include: A review of the clinical record revealed the following Physician's order, "Vigilon Monitor while out of bed-Fall Precaution ". The order was initiated on May 15, 2008, and updated order signed and dated January 1, 2010.	L 052	1. **Corrective Action(s)** An eye appointment for resident #3 was scheduled for 2/24/2010; vigilon monitor secured to chair of resident #9; the medical record for residents #3 & #15 cannot be corrected; The humidifier bottle for #20 was immediately refilled. 2. **Identification of Deficient Practices & Corrective Actions** A record review for consults (Opthalamology) was completed and all required follow-up appointments scheduled or done; residents with orders for sensors/alarms were identified and secured as indicated, MAR's were audited to determine compliance with standards for vital sign monitoring prior to administration of medication .eg. Digoxin and hypertensives. No other resident in the facility with tracheostomy/humidification care needs. Staff was re-educated on the requirement for assessment and documentation as a standard of medication administration. 3. **Systemic Changes** a) Residents using monitors sensors will be checked during intershift rounds for placement and function. Supervisory and managerial staff will increase monitoring for adherence. Inservice will be provided for staff regarding tracheostomy need for future residents. b) A review of MAR documentation will be incorporated during daily inter-shift report between charge nurses; mangers/ supervisors will increase the regularity of oversight for this performance . c) Physician's orders will be reviewed during the monthly certification process to ensure compliance with use of alarm. d) There will be a weekly audit of all MAR's.	

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L 052	Continued From page 4 On January 5, 2010 at approximately 3:00PM Resident #3 was observed sitting in a wheel chair in the dining area. No Vigilon alarm was noted on the wheel chair. A face-to-face interview was conducted with Employee #20 immediately after the observation. He/She acknowledged that the Vigilon Monitor was not on the chair as ordered by the physician. The record was reviewed on January 5, 2010. A. 3. The charge nurse failed to: assess the apical pulse prior to the administration of an antiarrhythmic medication for resident #3 The findings include: A review of the clinical record revealed the following Physician' s order, " Digoxin 2.5 ml (125mcg) by mouth every day for CHF - Hold for HR [heart rate] less than 60. " A review of the MAR [Medication Administration Record] revealed on September 5, 2009 and December 12, 13, 19, and 22, 2009 there were no heart rates documented. A face-to-face interview was conducted with Employee #5 at approximately 11:00AM on January 5, 2010. He/She acknowledged that the record lacked evidence that heart rates were obtained prior to the administration of digoxin as ordered by the physician. The record was reviewed on January 5, 2010. B. A review of the clinical record for Resident #15 revealed facility staff failed to obtain weekly vitals signs in accordance with physician ' s orders.	L 052	**4. Monitoring** Report compliance of weekly system changes to weekly/monthly QI meetings. **5. Compliance Date** 2/22/2010 **1. Corrective Action(s)** The MAR for residents #3 &#15 cannot be corrected retrospectively. **2. Identification of Deficient Practices & Corrective Actions** An audit was conducted on the MAR's of all residents who have a prescription for Digoxin and antihypertensives to determine compliance with standard. **3. Systemic Changes** a) Staff was reeducated on the requirement for assessment and documentation of vital signs (HR, BP) prior to administration of Digoxin and antihypertensives. b) A review of MAR documentation will be incorporated during daily inter-shift report between charge nurses. c) There will be a weekly audit of all MAR's by supervisory/managerial staff in addition to review during intershift report. **4. Monitoring** Report compliance to weekly/monthly meetings. **5. Compliance Date** 2/22/2010	

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L 052	Continued From page 5 Resident #15's diagnoses included hypertension. Physician ' s orders dated January 1, 2010 directed " Lisinopril 20mg twice daily for hypertension, monitor blood pressure and pulse weekly. " The Lisinopril (antihypertensive) order was initiated April 16, 2009. A review of the medication administration record (MAR) for the month of December 2009 lacked evidence that the resident ' s blood pressure and pulse were assessed the week of December 20, 2009. The MAR was annotated for the vital sign assessment to be performed on December 22, 2009. The space allocated for the December 22, 2009 blood pressure and pulse was blank. A review of nurse's progress notes for the week of December 20, 2009 lacked evidence that the resident's vital signs were assessed per physician's orders. A face-to-face interview was conducted with Employee #5 on January 5, 2010 at approximately 2 PM. He/she acknowledged the record lacked evidence that the resident's blood pressure and pulse were assessed as per physician's orders. The record was reviewed January 5, 2010. C. The charge nurse failed to ensure that the oxygen humidifier chamber was filled with water for Resident #20. Physician's orders dated January 3, 2010 directed "oxygen (to be administered at) 6/liters per minute at 35% humidified air via trach (tracheostomy) collar." An observation of the resident on January 8, 2009 at approximately 11 AM revealed oxygen	L 052		

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L 052	Continued From page 6 was connected to the resident's tracheostomy via trach-collar. The humidifier bottle had very little water remaining in the chamber. The resident was in no apparent distress and nodded in the affirmative when queried as to whether or not h/she was comfortable. A face-to-face interview was conducted with Employee #33 at approximately 11:01 AM on January 8, 2009. In response to a query regarding the lack of water in the humidifier bottle, Employee #33 acknowledged the lack of water and proceeded to replenish the chamber with water. 2. Based on observations, staff interview and record review it was determined that facility staff failed to supervise three (3) of 26 sampled residents that sustained falls and/or fall related injury and facility failed to provide an environment that is free from accident hazards. . Residents: #3, #6 and #9 The findings include: A. The charge nurse failed to adequately supervise Resident #3 who sustained a fall with injury. Review of Resident #3's record revealed a physician's order initiated May 15, 2008 and with the most recent updated order signed and dated January 1, 2010, revealed under "Restraints-Sensor Pad While In Bed". A review of an unusual occurrence report dated May 27, 2009 revealed that on May 27, 2009 resident "was observed lying on his/her bed,	L 052		

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L 052	Continued From page 7 resident was holding onto his/her left hand. Upon examination, noted that the wrist of left hand swollen. Resident stated that he/she fell during the early morning; he/she crawled back into bed. " An X-ray of the left hand was obtained on May 27, 2009 an it revealed a Colles' Fracture of the left wrist. A review of Resident #3's record revealed the care plan for falls dated April 09, 2009 did not identify a bed sensor under approaches. A face-to-face interview was conducted with Employee #5 at approximately 5:00PM on January 8, 2010. He/She acknowledged that the Bed Senor was not on the bed as ordered by the physician. Chart reviewed January 8, 2010. B. The charge nurse failed to adequately supervise Resident #6 who sustained repeated falls. A review of the medical record for Resident #6 revealed the resident sustained four (4) falls without injury on the following dates: November 1, 2009, November 12, 2009, December 11, 2009 and December 24, 2009. According to the Quarterly Minimum Data Set signed October 15, 2009, Resident #6 was coded in Section G, Physical Functioning, as extensive assistance required for transfers and total dependence for ambulation. Section J, Health Conditions was coded as unsteady gait. According to physician's orders dated January 1, 2010, a bed and wheelchair monitor/alarm was implemented August 6, 2009 for fall prevention.	L 052		

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L 052	Continued From page 8 A nurse's progress note dated December 24, 2009 at 12 noon revealed the following account of the most recent fall sustained by the resident: "...resident requested to go to the toilet. Assisted to the toilet ...After 15 minutes, resident was found sitting on the floor in front of the toilet room ..." The record lacked evidence that facility staff intervened in an attempt to prevent the fall sustained December 24, 2009 and there was no evidence that the resident was observed attempting to transfer without assistance. The record lacked evidence that Resident #6, who sustained repeated falls, was adequately supervised to prevent falls. He/she was assisted to the and later "found" in front of the toilet room. The record was reviewed January 6, 2010. C. The charge nurse failed to adequately supervise Resident #9 who sustained a fall with injury. A review of the "Occupational Therapy Plan of Care for Rehabilitation" dated August 20, 2009 revealed "Slides forward in reclined chair feet unsupported on [bilateral] leg rests." A review of Resident #9 clinical record revealed the following nursing notes, "Responded to Vigilon monitor. Resident observed slid out of Geri chair to the floor. No injury noted. Upper and lower extremities movable without difficulty. Neuro checks initiated. "The note was dated September 12, 2009 at 12MD [mid day]. A review of an Unusual Occurrence/Incident Report for Resident #9 revealed the following	L 052		

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L 052	Continued From page 9 documentation dated September 13, 2009, "MD [Medical Doctor]/RP [Responsible Party] aware. Resident transferred to ER [Emergency Room via 911 as per family's request for evaluation." Discharged instructions from [hospital] revealed "a concussion". Discharge instructions were dated September 13, 2009. A review of the "Occupational Therapy Plan of Care for Rehabilitation" dated November 27, 2009 revealed "Pt [Patient] received new Geri recliner chair. Positioned well. Recommend that resident use geriatric recliner when out of bed, that recliner be kept in reclined position when not eating/drinking. " A face-to-face interview was conducted with Employee #24 at approximately 5:00PM on January 8, 2010 stated "I was informed by the nurses and the family that the brake lock to recline on [Resident #9] Geri chair was not working .... With the malfunction of the brake, [Resident #9] Geri chair could not recline. A new Geri chair was ordered. " The record was reviewed on January 8, 2010.	L 052		
L 067	3214.1 Nursing Facilities A comprehensive on-going in-service education program shall be provided by the facility and shall include training on the provision of resident care. This Statute is not met as evidenced by: Based on review of the Abuse and Neglect Policy and staff interview for three (3) of five (5) newly hired employees, it was determined that the facility failed to ensure that abuse training statements were signed prior to the first day services were provided to the residents.	L 067		

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L 067	Continued From page 10 The findings include: A Review of Facility Policy No.: TX-0001.97 Abuse, Neglect and Mistreatment states: "Procedure: 1. They will be asked to read a statement of resident rights and a statement that defines verbal, mental, and physical abuse and neglect, sign a statement agreeing that they will have a duty to uphold residents rights, to protect the residents from any form of abuse or neglect, and to report any suspected abuse or neglect." A review of three (3) personnel records on January 6, 2010 revealed the following: Newly Hired Employee #1 was hired December 14, 2009 as a nursing assistant and was currently working in that position. His/Her personnel file lacked documentation of a signed abuse training statement as per the facility's policy. Newly Hired Employee #2 was hired November 9, 2009 as a Licensed Practical Nurse in the nursing department and was currently working in that position. His/Her personnel file lacked documentation of a signed abuse training statement as per the facility's policy. Newly Hired Employee #3 was hired October 28, 2009 as a Registered Nurse in the nursing department and was currently working in that position. His/Her personnel file lacked documentation of a signed abuse training statement as per the facility's policy. The facility failed to have three newly hired employees sign the abuse training statement as per the facility' s policy agreeing that they will have a duty to uphold residents ' rights, to protect	L 067	**1. Corrective Action(s)** The three newly hired employees, who did not have abuse training statements on file, reviewed the policy and signed statements are on file . **2. Identification of Deficient Practices & Corrective Actions** The files of all employees hired within the last quarter were audited. All employees' personnel files reviewed had signed training statements **3. Systemic Changes** The issuance of the Abuse and Neglect Acknowledgement training checklist were re-implemented into the orientation and on-going staff development program January 6, 2010. During monthly orientations and training sessions, the facilitator will be responsible for distributing the training statements, collecting the signed statements by the end of day 2, and returning them to the HR department for filing. **4. Monitoring** Personnel files will be audited by HR Specialist on a quarterly basis, focusing on 100% compliance for filed abuse & neglect training statements. This will be reported to the QI committee quarterly. **5. Compliance Date** 2/22/1010	Jan., Apr. July, Oct. 2010

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L 067	Continued From page 11 the residents from any form of abuse or neglect, and to report any suspected abuse or neglect." A face-to-face interview was conducted on January 6, 2010 at approximately at 4:00 PM with Employee #13. He/she acknowledged that the newly hired employee files lacked signed abuse training statements.	L 067		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: 1. Based on observations, record review and staff interview it was determined that the charge nurse failed to maintain appropriate infection control practices as evidenced by: failure to ensure that isolation carts were maintained in sanitary condition, that four (4) of five (5) ice machines were kept clean, failed to maintain aseptic technique during a dressing change for one (1) of six (6) residents and incontinence and indwelling catheter care for one (1) of four (4) residents. Residents# 7 and 8. The findings include: A. The charge nurse failed to practice in a manner to prevent the spread of infection. A. 1. At approximately 10:00AM on January 7, 2010 Employee #34 was observed removing an isolation cart from the hallway and placing it into Room 354. The resident in Room 354 was known to be on Contact Isolation for Clostridium Difficile (C-Diff) in his/her stool. The employee	L 091		

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L 091	Continued From page 12 was observed replacing the cart into the hall at the completion of the fire drill without sanitizing it. A face-to-face interview was conducted with the employee immediately after the occurrence. He/she acknowledged the finding at that time. A. 2... At approximately 10:20AM on January 7, 2010 Employee #35 was observed removing an isolation cart from the hallway and placing it into Room 307. The resident in Room 307 was known to be on Contact Isolation for Clostridium Difficile (C-Diff) in his/her stool. The employee was observed replacing the cart into the hall at the completion of the fire drill without sanitizing it. A face-to-face interview was conducted with the employee immediately after the occurrence. He/she acknowledged the finding at that time. B. Four (4) of five (5) ice machines located in the residents' areas were soiled and in need of cleaning. C. Facility staff failed to observe infection control and personal hygiene protocol during and after incontinence and catheter care for one (1) resident. Resident # 7. Resident # 7 and was admitted to the facility HA on June 24, 2005. According to an annual Minimum Data Set (MDS) completed on January 1, 2009, the resident's coded diagnoses included diabetes mellitus, peripheral vascular disease, arthritis, osteoporosis and urinary tract infection (UTI), Section I (Disease diagnoses). According to the quarterly MDS completed on December 14, 2009, the resident was coded zero (0) for long and short term memory, able to recall current season, staff names/faces, and that he/she is in a nursing home, makes independent decisions regarding tasks of daily life with periods of lethargy. Section B (Cognitive Patterns).	L 091	**1. Corrective Action(s)** a) The isolation cart in question was sanitized after the observation. b) 4 of the 5 ice machines were cleaned and reinspected. c) Employee 32 and 33 were counseled/ re-educated on proper infection control practices while providing perineal care on a resident who has an indwelling catheter. d)Employee 29, 30, 32, and 33 were counseled/re-educated on proper glove use, handwashing and surface cleaning as key points during care procedures. **2. Identification of Deficient Practices & Corrective Actions** This observation was made on one unit during the fire drill. There was no other resident requiring isolation at time of the drill. Staff on all units were educated regarding the isolation standard and the change in practice during fire drills. **3. Systemic Changes** a) Several system changes were implemented. These include a revision of the dressing change checklist to observe glove use, handwashing, environmental controls to prevent the spread of infection cleaning process and cleaning schedule for the ice machines. The fire drill checklist was revised to include staging of adherence to infection control practice during the drills. b) Direct observations of caregiver staff performing procedures relating to infection control, i.e., dressing change, perineal care, catheter care. Increased emphasis will be placed on these areas during new employee orientation and mandatory annual competencies.	

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L 091	Continued From page 13 He/she is understood and understands others. Section C (Communication/Hearing Patterns). Section E (Indicators of depression, anxiety, and sad mood): Here the resident was coded zero (0), meaning no indications for depression, anxiety, and sad mood. Resident #7 was coded as totally dependent on staff for bed mobility, toilet use and bathing, extensive assistance with dressing and personal hygiene, transfer, and walk in room, corridor, and locomotion on and off unit did not occur. He/she was unable to attempt test of balance while standing and presents with limited range of motion on both lower extremities including hip, knee, ankle and toes. Section G 3 and 4 (Test of balance and Functional Limitation in Range of Motion). He/she is incontinent of bowel and has an indwelling catheter. Section H (Continence). The resident was observed during incontinent care on January 7, 2010 at approximately 12:30 PM. He/she had an indwelling catheter. Employees # 32 and 33 were observed providing bowel incontinence and catheter care to Resident # 7. The resident had a large quantity of loose stool in the incontinent pad. Employee #33 was observed wiping the resident from the back to the front, (From the anal area to the vaginal area). A further review of the resident's clinical record revealed that the resident was treated with antibiotics for UTI, in March 20 to 30, 2009, August 25 to September 4, 2009, November 22 to 30, 2009 and December 18 to 23, 2009. Employee # 33 failed to follow appropriate personal hygiene protocol while providing bowel incontinence and catheter care to Resident #7 when a large quantity of stool soiled the buttocks.	L 091	**4. Monitoring** Findings and outcomes will be reported the QI committee. **5. Compliance Date** 2/22/2010 **1. Corrective Action(s)** Environmental Services Department (ESD) immediately initiated cleaning of all ice machines. **2. Identification of Deficient Practices & Corrective Actions** Ice machines will be cleaned daily by Environmental Services Department and inspected by supervisors. **3. Systemic Changes** The existing cleaning process was revisited, ESD staff and supervisors were retrained on addressing ice machines cleanliness. **4. Monitoring** These areas will be monitored daily by ESD supervisors and weekly by ESD manager. Ice machine cleanliness conditions will be audited monthly and reported during quarterly QI meeting. **5. Compliance Date** 2/22/2010	

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L 091	Continued From page 14 Employees #32 and 33 failed to change their gloves and wash their hands after providing bowel and bladder incontinent care to Resident # 7. Employee # 33 was observed handling the resident his/her television remote control with the unchanged soiled gloved hands used to provide bowel and bladder incontinent care. Wearing the soiled gloves used to provide incontinent care to the resident; Employee # 32 proceeded first to the bathroom to discard the bowl of water used for the incontinent care and then went into the resident's closet. Employees # 32 and 33 removed the soiled gloves just before they exited the resident's room. Employee # 32 failed to observe infection control protocol after providing incontinence and catheter care to Resident #7. A face-to-face interview was conducted with Employees #32 and 33.on January 7, 2010 at approximately 1:30 PM. They both acknowledged the aforementioned observations. D. During a wound treatment observation on January 5, 2010 it revealed that Employee #29, failed to maintain consistent use of aseptic technique during a wound treatment by not washing hands between cleaning of the right heel wound and dressing of the right heel wound. Also Employee #29 who was assisted by Employee #30 failed to cleanse surface of bedside table following a wound treatment of Resident #8. According to the Quarterly Minimum Data Set (MDS) for Resident #8 completed October 6,	L 091	**1. Corrective Action(s)** The isolation cart was immediately sanitized. **2. Identification of Deficient Practices & Corrective Actions** This observation was made on one unit during the fire drill. **3. Systemic Changes** a) The Fire Safety and Drill training procedures were revised for Employee Orientation and mandatory annual in-services. The revision will reflect appropriate infection control practices during drills. b) Infection control practices will be staged during fire drills. **4. Monitoring** Drill outcomes will be monitored and reported Bi-monthly to the QI and Safety committees. **5. Compliance Date** 2/22/2010	

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L 091	Continued From page 15 2009 "Section M Skin Condition M1d # of Stage 4 ulcers was coded one (1); M2a Pressure Ulcer was coded 4. Review of the " Physician ' s Order Form dated and signed January 6, 2010 directed Cleanse right heel ulcer with soap and water pat dry multiple swab every skin prep, to peri wound redness reusing." A face-to-face interview was conducted on January 5, 2010 at approximately 12:40 PM following wound treatment with Employee #29 and Employee #30. After review of the wound treatment process used, both employees acknowledged the break in maintaining aseptic technique during a wound treatment. A face-to-face interview was conducted on January 8 at approximately 2:30 PM with Employees #15 and 16. After review of the wound treatment process used, both Employees acknowledged that there was a break in aseptic technique used during the wound treatment. 2.. Based on observation, record review and staff interview, it was determined that facility staff failed to place Resident #23 on isolation precautions after a positive Vancomycin Resistant Enterococcus (VRE) urine test. The findings include: A review of the clinical record revealed a report of a urine culture that was positive for VRE. The report of the culture was dated January 2, 2010. Hand written documentation on the lab report stated, " Dr. [name] made aware 11:00AM 1/2/10. A review of the Physician's Order Sheet (POS) on the record revealed the following telephone	L 091		

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L 091	Continued From page 16 orders, "Nitrofurantoin Sustained release 100mg by mouth twice daily for Urinary Tract Infection for seven days. Contact Isolation for VRE in urine. " The telephone orders were signed by the physician on January 4, 2010. Another physician's order dated and signed on January 4, 2010 revealed the following, "Discontinue contact isolation. Not needed per our policy. " A review of the facility's Infection Control Isolation Policy: #IC-00022.96 revealed the following statement under the heading of Control Measures on Page 17 of 21. "Any patient/resident with a positive culture for VRE from any site is placed in a private room with a private bath." Item #2 of the policy stated, "A sign is placed on the patient/resident door which will read STOP, Report to the nurse before entering " and Item #10 stated, "Patients/Residents readmitted to this facility who are known to have been previously colonized with VRE will be placed on Contact Isolation until confirmed culture negative (rectum). A face-to-face interview was conducted with Employee #15 at approximately 2:00PM on January 8, 2010. He/she acknowledged that the resident should have remained on Contact Isolation until a negative culture (rectum) was confirmed as recommended by the facility's policy. The record was reviewed on January 8, 2010.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), and Chapter 24 through 40. This Statute is not met as evidenced by:	L 099		

Health Regulation Administration

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L 099	Continued From page 17 Based on observations that were made during a tour of the dietary services on January 5 and 6, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions. The findings include: 1. Seventeen (17) of seventeen (17) water pitchers and six (6) of six (6) small fruit storage containers were badly stained and discolored. 2. The top and bottom sections of one (1) of one (1) convection oven were covered with burnt grease residue and food debris. 3. Four (4) of four (4) temperature gauges on the warmer box were damaged and needed to be replaced. 4. Forty-five (45) of forty-five (45) coffee cups were stained with leftover coffee residue and the coffee machine was dusty. 5. The following pieces of equipment were soiled and in need of cleaning or replacing: a. Two (2) of seven (7) four-inch full pans. b. Two (2) of two (2) double handle soup pots. c. One (1) of One (1) small soup kettle and One (1) of one (1) large soup kettle which also leaked. d. Four (4) of four (4) fryer baskets. e. The fire suppression system. f. One (1) of one (1) warmer box. g. One (1) on one (1) juice machine. h. One (1) of one (1) microwave oven. 6. The dishwasher logs were not completely filled out during the months of February 2009 thru December 2009. 7. The cloth cover for the piano in the residents	L 099	1. **Corrective Action(s)** All pitchers, small fruit storage containers were removed from the shelf, cleaned and sanitized. The ovens were immediately scoured and cleaned of burnt grease and residue. The temperature gauges for the warmer box were replaced. Coffee cups were cleaned with a stain remover and sanitized. The pots and pans, microwave was cleaned and sanitized. Dishwasher temperatures were recorded by engineers and met regulatory requirements. They will be taken consistently and recorded as required. Temperatures were recorded by engineer from March 2009 through December 2009 to ensure proper temperatures). The piano cover will be replaced. 2. **Identification of Deficient Practices & Corrective Actions** All dietary staff were in-serviced to ensure understanding of consistently recording temperatures, proper cleaning of equipment and service wares as a key indicator of proper sanitation. 3. **Systemic Changes** Logs and cleaning process will be monitored daily by shift supervisors and monthly inspections done by the District Manager for the Food Service company. Daily visual inspections will be done supervisor and Manager to ensure proper cleaning and sanitizing of all utensils, service ware and equipment; monthly inspections of the Food Service Department to ensure continued compliance. 4. **Monitoring** Report outcomes of inspection to Quality Improvement Committee monthly. 5. **Compliance Date** 2/22/2010	

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L 099	Continued From page 18 dining area located on the first floor was stained. These observations were made in the presence of employee # 9 who acknowledged these findings during the survey.	L 099		
L 167	3227.18 Nursing Facilities Each facility shall comply with all applicable District and federal laws, regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute is not met as evidenced by: Based on record review (Medication Administration Record (MAR), physician's order and Controlled Drug Receipt/Record/Disposition Form), it was determined that the facility failed to record the administration of a controlled substances for four (4) of eleven (11) residents. Residents #8, JKG1, JKG2 and JKG4 The findings include: 1. On January 5, 2009, at approximately 2:00 PM, a review of Resident JKG1's medical record revealed a physician's order, dated December 28, 2009. The order states, "Morphine Sulfate IR concentrate, 20mg/ml, 7.5mg, via G-tube, every hour as needed for pain or shortness of breath." The Controlled Medication Utilization Record was reviewed and indicated that 0.375ml (7.5mg) of Morphine Sulfate was removed from the 30cc stock bottle on January 3, 2010 at 4pm and 10pm. For the same date and time indicated, the resident's MAR was blank. There was no additional information provided on the back on the resident's MAR.	L 167	**1. Corrective Action(s)** Residents #8 JKG1, JKG2 and JKG4 pain was controlled by the pain management program. These records cannot be retroactively reconciled. However, the narcotic count was correct. Licensed nursing staff were immediately re-educated/counseled on the standard and legal requirement for accuracy in documentation of all medications particularly controlled substances.	

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L 167	Continued From page 19 2. On January 5, 2009, at approximately 2:15 PM, a review of resident JKG2 medical record revealed a physician's order, dated December 7, 2009. The order stated, "Oxycodone Immediate Release 5mg capsule, 1 capsule by mouth every 6 hours, as needed for pain". The Controlled Medication Utilization Record was reviewed and indicated that 1 capsule was removed December 19, 2009 at 10:00am. For the same date and time indicated, the resident's MAR was blank. There was no additional information provided on the back on the resident's MAR. 3. On January 5, 2009, at approximately 2:30 PM, a review of resident #8 medical record revealed a physician's order, dated December 6, 2009. The order states, "Oxycodone Immediate Release 5mg capsule, 1 capsule by mouth every 6 hours, as needed for right heel pain prophylaxis wound care and left hand pain". The Controlled Medication Utilization Record was reviewed and indicated that 1 capsule was removed November 30, 2009 at 2:15AM. For the same date and time indicated, the resident's MAR was blank. There was no additional information provided on the back on the resident's MAR. 4. On January 5, 2009, at approximately 2:45 PM, a review of Resident JKG4's medical record revealed a physician's order, dated January 1, 2010. The order states, "Oxycodone Immediate Release concentrate, 20mg/ml. Give 0.25ml (5mg) sublingually 3 times a day for pain". The MAR was reviewed and indicated that the medication was administered January 6, 2010 at	L 167	**2. Identification of Deficient Practices & Corrective Actions** PRN audits were conducted to ensure proper compliance with documentation on the MAR. The controlled medication utilization records and MAR's for January through February 22, 2010 were reviewed for compliance and reconciliation. **3. Systemic Changes** a) Managers and supervisors have received training on conducting med pass. The managers and supervisors will do direct observation of med pass to ensure immediate documentation after medication administration. b) MAR and narcotic records are reviewed during intershift reports. c) There will be continued emphasis on documentation of controlled substances on both MAR and Controlled Medication Utilization Record as an essential requirement for administration and management of these substances during orientation competencies evaluation of licensed staff as a criteria for acceptable performance. **4. Monitoring** Clinical managers/designee to report at the weekly Focus QI meeting to discuss trends. Quality Improvement committee will report Weekly on analysis and trends. Clinical managers/designee to report at monthly QI meeting on analysis and trends. **5. Compliance Date** 2/22/2010	

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L 167	Continued From page 20 6:00AM. For the same date and time indicated, the resident's Controlled Medication Utilization Record was blank.	L 167		
L 183	3229.5 Nursing Facilities The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record, reviewed quarterly, and revised as necessary. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 26 sampled residents, it was determined that the social worker failed to perform quarterly assessments. Residents #6, 11 and 16. The findings include: 1. The social worker failed to document in Resident #6 ' s record every 90 days. A review of Resident #6 's clinical record revealed the most recent social services assessment was documented September 1, 2009. There were no social work entries subsequent to this date. The record lacked evidence of a social work assessment for December 2009. The record was reviewed January 6, 2010. 2. The social worker failed to document in Resident #11's record every 90 days. A review of Resident #11's clinical record revealed the most recent social services assessment was documented September 10, 2009. There were no social work entries subsequent to this date.	L 183	1. **Corrective Action(s)** The records of residents #'s 6, 11, and 16 for overdue notes can not be corrected retrospectively. The residents were reassessed and an 'interim' update was done. 2. **Identification of Deficient Practices & Corrective Actions** A review of past and current quarterly schedules were done to identify other records that could be out of compliance. Records were brought into compliance if indicated. 3. **Systemic Changes** Medical record team will increase focus audit of this requirement during weekly concurrent audits.	

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L 183	Continued From page 21 The record lacked evidence of a social work assessment for December 2009. The record was reviewed January 5, 2010. 3. A review of Resident #16's record revealed a social worker quarterly note dated July 20, 2009. There was no evidence in the record that a quarterly review or an assessment was documented after July 20, 2009. A face-to-face interview was conducted with Employee #11 on January 7, 2010 at 12:30 PM. The social worker stated that he/she was short staffed and acknowledged that social service notes were not completed. The record was last reviewed January 7, 2010.	L 183	**4. Monitoring** All social workers will conduct monthly audits of records to determine continued compliance and report outcomes to the Quality Improvement committee monthly. **5. Compliance Date** 2/22/2010	
L 189	3230.5 Nursing Facilities The responsibilities of the director of the activities program or his or her designee shall include, but not be limited to, the following: (a)To provide direction and quality guidelines of the program (b)To develop and maintain a plan for the program and procedures for implementing the plan; (c)To plan and budget for the program, including the number and levels of employees to be hired and the equipment and supplies to be purchased; (d)To coordinate and integrate the program with other resident care services provided in the facility and in the community;	L 189		

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L 189	Continued From page 22 (e)To assist in the development of and participate in staff orientation and annual education programs for all staff in the facility; (f)To develop a written monthly activities schedule in a large print calendar that includes date, time and location of each scheduled activity; (g)To post the activities schedule on the first working day of each month at each nursing unit, at a height that can be clearly seen by residents in wheelchairs; (h)To assure that visually, hearing and cognitively impaired residents know about posted activities; (i)To assess the therapeutic activity needs and interests of each resident within fourteen (14) days of admissions; and (j)To participate in the development of an interdisciplinary care plan and reassess each resident's responses to activities at least quarterly after reviewing with each resident his or her participation in the activities program. This Statute is not met as evidenced by: Based on observation and staff review, it was determined that the director of the activities program or his or her designee failed to post the activities schedule on the first working day of the month at each nursing unit, at a height that can be clearly seen by residents in wheelchairs. The findings include: According to 22 DCMR 3230.5 stipulates, "The responsibilities of the director of the activities	L 189	1. **Corrective Action(s)** The calendar is prepared by an outside vendor and has been delivered and posted on time over the last five(5) years. The January 2010 calendar was posted on 1/7/2010. 2. **Identification of Deficient Practices & Corrective Actions** The residents were not adversely affected because an alternate plan was implemented effective 1/1/2010. Typed calendars were posted in large print on each unit for the week of 1/1/2010 to 1/7/2010. In addition, each resident received notice of daily activities and over-head announcements were made.	1/7/2010

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	HFD02-0005	A. BUILDING _____ B. WING _____	01/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 189	Continued From page 23 program or his or her designee shall include, but not be limited to, the following: "...(f)To develop a written monthly activities schedule in a large print calendar that includes date, time and location of each scheduled activity; (g)To post the activities schedule on the first working day of each month at each nursing unit, at a height that can be clearly seen by residents in wheelchairs." An observation on January 5 and 6, 2010 revealed that there were no posted written monthly activities schedules in a large print calendar that includes date, time and location of each scheduled activity. A face-to-face interview was conducted with Employee #10 on January 6, 2009 at approximately 4:30 PM. He/she acknowledged that there were no activities calendars posted. He/she also presented the surveyor with a tracking notification form revealing that the calendars are scheduled for delivery on January 7, 2010.	L 189	**3. Systemic Changes** a) Handwritten monthly calendars will be posted in the event of a shipment delay. b) The facility has identified another vendor as an alternate in the event of a shipping delay. The facility and the vendor agreed to a tracking of shipment to ensure a timely arrival. **4. Monitoring** Any variation from the requirement to post the calendar by 1st of the month will be reported to the QI committee for revised corrective action. **5. Compliance Date** 2/22/2010 **1. Corrective Action(s)** This incident was investigated two years ago. It was determined that the employee exercised poor judgment when he accepted gifts/gratuities from a resident's family member. The employee was counseled and reassigned to another unit.	Ongoing
L 207	3232.5 Nursing Facilities Incidents of abuse or neglect resulting in injury to a resident, or incidents of misappropriation of a resident's funds, shall be reported immediately to the appropriate agencies, including the Department of Health, the Metropolitan Police Department, the Long Term Care Ombudsman and Adult Protective Services. This Statute is not met as evidenced by: Based on record review, family and staff interview for one (1) of 26 sampled residents, it was determined that the facility failed to notify the State Agency of alleged misappropriation of resident/family funds. Resident #4.	L 207	**2. Identification of Deficient Practices & Corrective Actions** No other incident of staff accepting gifts or gratuities from residents or their family members was identified; Staff was informed of the seriousness of this and to decline such offers. (This family member questioned the decision that he/ she should not offer gifts to the staff for services provided and was provided an alternative to recognizing staff. He/She was encouraged to write a letter of commendation to the employee. The resident did and the commendation was forwarded to the personnel file.) The Employee Handbook is under revision and this standard of conduct will be addressed; Will request a memo from Human Resources to all employees	

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L 207	Continued From page 24 A face-to-face interview was conducted with Resident #4's family member at approximately 3:45PM on January 6, 2010. During the interview the family member stated that Employee #33 had accepted gifts of clothing and requested and received a loan of $20.00 from him/her. During a face-to-face interview conducted with Employee #33 at approximately 4:00PM on January 7, 2010; the employee stated, "The only thing he/she ever gave me was a pair of canvas shoes." Employee # 33 denied ever requesting and/or receiving money from the family member. Another face-to-face interview was conducted with Employees #1 and 2 at approximately 4:30PM on January 7, 2010. Both Employees acknowledged being informed of the family member's allegation that Employee #33 had accepted clothing and money from him/her. Both Employees also acknowledged that they failed to notify the State Agency of the allegation of misappropriation of family/resident funds for Resident #4.	L 207	regarding this conduct; Training programs will be designed for all levels of staff during orientation, Department/Division meetings etc. Emphasize resident rights, abuse and neglect, misappropriation of funds, identification of these kinds of incidents as 'unusual' which warrants investigation and reporting to State Agency. **4. Monitoring** Continue reports to Quality Improvement Committee on reported instances of Abuse and Neglect **5. Compliance Date** 2/22/2010 **1. Corrective Action(s)** i. All 3B doors, walls and/or door jams that were identified as marred were repaired beginning on 2/19/2010. ii. A contracted vendor was dispatched to provide a proposal to replace flooring in resident's room. No hazardous situation exists. Repairs will be completed as soon as it is possible to relocate the resident. iii. The Environmental Services Department immediately initiated cleaning of all the ice machines identified. iv. The bottles of eyewash solutions were removed from service immediately and replaced. The expiration date of the replacement bottles is 8/2010. **2. Identification of Deficient Practices & Corrective Actions** i. Doors, walls and door jams were inspected by maintenance staff on a daily basis for mars/scars. ii. At the request of TWH administrator, vendor provided written documentation that the existing floor damage was not a safety concern. All other rooms were inspected and repairs scheduled as indicated. iii. Ice machines will be cleaned daily by the	
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 6 and 7, 2010, it was determined that the maintenance department failed to provide effective maintenance services in 14 of 66 residents rooms observed. The findings include:	L 410		

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L 410	Continued From page 25 1. Doors, walls and/or door jams were marred in thirteen (13) of sixteen (16) rooms surveyed on unit 3B. 2. The floor was damaged in room #356A as evidenced by a 3x3 dented area next to the resident's bed. 3. Four (4) of five (5) ice machines located in the residents areas were soiled and in need of cleaning. 4. Two (2) of two (2) eyewash solution bottles were expired since September 2007 in the beauty shop. These findings were acknowledged by Employee # 14 who was present at the time of observation.	L 410	environmental Services Department staff and inspected by supervisors. **3. Systemic Changes** i. Once residents are discharged, the entire room will be inspected for mars/scars and repairs initiated as part of the terminal cleaning process. ii. Doors, walls and door jams are now a part of the daily room inspection for the plant operations department. The Plant Operations staff were retrained on the importance of observing door surfaces. All identified doors will be priority for repairs and maintenance. iii. Floor conditions are now a part of the daily room inspection for the Plant Operations department. iii. The existing cleaning process was revisited. ESD staff and supervisors were retrained on addressing ice machines cleanliness. iv. Eyewash stations will be monitored during environmental rounds **4. Monitoring** i. Follow-up inspection by Plant Ops Leadership will be done weekly. Doors and door frames/jams condition and status of repairs will be reported to quarterly QI meetings. ii. These areas will be monitored daily by the maintenance technicians and reported to supervisory staff. iii. These areas will be monitored daily by ESD supervisors and weekly by ESD manager. iv. Ice machine cleaning as an item for monitoring is on the environmental checklist. Findings from environmental rounds will be reported to Safety/QI committee. **5. Compliance Date** 2/22/2010	Feb., May Aug., Nov 2010

Mills, Sharon (DOH)

From: Donna Williamson [DWilliamson@thewashingtonhome.org]
Sent: Monday, March 08, 2010 1:57 PM
To: Mills, Sharon (DOH)
Subject: TWH Plan of Corrections Final
Attachments: twh fy 2010 fed 2567-FINAL.doc; twh fy 2010 ost2567-FINAL.doc

Good Afternoon Ms. Mills:

Please access the attachments to find the revised 'FINAL' Plan of Corrections submitted by the Washington Home for the recertification survey conducted January 4 – 8 2010. The original signed documents have been forwarded by mail.

You may contact me, if you have any questions at (202) 895-7618 or (202)895-0101.

Thank you for your attention to this matter.

Donna Allen Williamson