

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

*POC*  
*Receipt*  
*Sept 10/2007*  
*(9/10/07)*  
*accepted*  
*9/19/07 ms*

PRINTED: 08/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/24/2007</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS  An annual recertification survey was conducted on August 22 through 24, 2007. The following deficiencies were based on observations and record review. The sample size was 13 residents based on a census of 49 residents the first day of survey.	F 000	F 000  <b>THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN THE HIGH QUALITY OF CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.</b>	
F.323 SS=E	<b>483.25(h) ACCIDENTS AND SUPERVISION</b>  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain an environment free of accident hazards.  The findings include:  1. The floor in the main kitchen was observed with a loose tile directly behind the serving area on August 22, 2007 at 9:50 AM in the presence of Employee #1.  2. The floor in the walk in refrigerator was observed to be unsecured, moved when walked on and the metal panels were bent in an upward curve on August 22, 2007 at 10:05 AM in the presence of Employee #1.  The above findings were acknowledged by	F 323	1. The loose tile observed directly behind the serving area was removed, cleaned and cemented in place. Grouting was redone. 2. Entire kitchen tile floor area was inspected by maintenance staff and no other repairs were required. 3. Maintenance and Food Service staff will inspect and repair loose tiles as they are identified. Quotes are being considered for re-tiling the entire floor area. 4. Flooring surface has been added to the quarterly QA report and will be monitored.  1. Curved floor panels will be secured with Pro Con 5" screws to concrete below. Diamond Tread Aluminum ordered for floor coverage per Kolpak representative. Expected delivery and installation 09/11/07. 2. Complete inspection of walk-in refrigerator and no other raised panels found. 3. Food Service Staff educated to report any future variance in floor surface to Dining Services Manager. Maintenance staff will repair. 4. Flooring surface has been added to the quarterly QA report and will be monitored by Dining Services Manager.	08/27/07 08/27/07 08/27/07 08/27/07  09/11/07 08/27/07 08/27/07 08/27/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>SL L</i>	TITLE  <b>CEO / ADMINISTRATOR</b>	(X6) DATE  <b>10 SEPT 2007</b>
--	---	--------------------------------------

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.

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

PRINTED: 08/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/24/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008</b>		
(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 323	Continued From page 1	F 323			
F 363 SS=F	<p><b>Employees #1 and 2 at the time of the observations.</b></p> <p><b>483.35(c) MENUS AND NUTRITIONAL ADEQUACY</b></p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the lunch meal on August 23, 2007, it was determined that the amount of each food item to be served was not indicated on 26 of 31 resident meal tickets and the correct scoop size was not used to serve food items during the lunch meal. These observations were made in the presence of Employee #1.</p> <p>The findings include:</p> <p>1. Residents' meal tickets failed to list the number of ounces for each food item served.</p> <p>The following food choices were listed on the "regular" diet menu for the lunch meal on August 22, 2007:</p> <p>Shepherd's Pie Baked Turkey Wings Sandwich - asst'd Rice Pilaf Green Beans Spinach Garden Salad w/House Dressing</p>	F 363	<ol style="list-style-type: none"> <li>Dietary uses a software program (Meal Tracker) to ensure the accuracy of resident meals. The program's parameters have been changed to include portion sizes for each food item.</li> <li>All resident profiles were compared to the corresponding diet order to guarantee proper diet, portion size, and diet modifications are correctly recorded.</li> <li>In-services with dietary staff to increase knowledge and awareness of appropriate portion size for each diet.</li> <li>Director of Dining Services with the assistance of the Dietitian will monitor, and results will be reported to the QA committee.</li> </ol>	<p>8/27/2007</p> <p>8/29/2007</p> <p>8/27/2007-Ongoing</p> <p>8/26/2007</p>	



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

PRINTED: 08/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/24/2007
NAME OF PROVIDER OR SUPPLIER  METHODIST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		
(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 363	Continued From page 3 following ounces of food to be served:  Two (2) regular diet meal tickets indicated 6 oz. of Shepherd's pie be served. Three (3) regular and one (1) "No concentrated sweets" pureed diets indicated 8 oz. of Shepherd's pie be served. Three (3) "No added salt" and "No concentrated sweets" diets indicated 6 oz. of Shepherd's pie be served. One (1) regular ground and one (1) regular mechanical soft diet indicated 6 oz. of Shepherd's pie be served.  The Shepherd's pie for both regular and pureed texture was observed to be served with a 10 oz. scoop. The mechanical soft diets received chopped turkey meat and were served with a 10 oz. scoop.  Green beans and rice pilaf were observed being served on each plate that was not a pureed texture. However, these items were not listed on the special diet menus.  Employee #1 acknowledged the above findings at the time of the observations.	F 363			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the main	F 371			



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

PRINTED: 08/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/24/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008</b>	
(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 REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5  Refrigerator #1: Sweet pickles dated as opened on February 27, 2007, cucumber chips dated March 10, 2007, sliced apples dated August 14, 2007, white American cheese dated July 23, 2007, Monterey Jack cheese opened with no date.  Walk in refrigerator: 3 pans of chicken not labeled or dated, brisket and ribs (left over foods) unlabeled and undated, 249 cartons of skim milk expired between August 10 through August 18, 2007 and two (2) containers of dispenser milk that expired August 16, 2007.  Freezer: pearl onions were uncovered, undated and unlabeled, a plastic bag of biscuits were undated and unlabeled, a package of turkey bacon was dated on the box as March 16, 2006 and undated as to the open date, and a package of onion rings was observed with ice crystals formed on the inside of the bag.  6. Items on the steam table were tested for temperatures at the lunch meal on August 23, 2007 at 12:30 PM. The holding temperatures for pureed turkey was observed to be 132 degrees F and pureed green beans were observed to be 110 degrees F.	F 371	1. All food items which were identified as out of compliance were destroyed. 2. A comprehensive review of all food storage areas was conducted to identify any further food items which were out of date, or were not labeled/dated. 3. Dietary staff was in serviced on the correct usage of left over food, including the correct procedures for wrapping, labeling, and dating. 4. Daily monitoring of food storage areas by Dining Services Director and Chef Manager.	8/22/2007  8/23/2007  8/27/2007  8/29/2007
F 465 SS=F	Employee #1 acknowledged the above findings at the time of the observations. <b>483.70(h) OTHER ENVIRONMENTAL CONDITIONS</b>  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	1. New steam table ordered by Methodist Home. 2. New steam table installed. 3. Temperatures of all food items will be recorded prior to service at each meal period. Any non compliant food will be brought up to temperature or discarded. 4. Director of Dining Services and Chef Manager to monitor temperature charts daily. Director of Dining Services will monitor and results will be reported to the QA committee.	08/13/2007 09/07/2007 08/23/2007 08/23/2007

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

PRINTED: 08/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/24/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008</b>	
(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 465	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain an air gap in three (3) of three (3) ice machines. These observations were made in the presence of Employees #1 and 2.  The findings include:  The ice machines in the main kitchen, 1st floor pantry and 2nd floor pantry were observed to have no air gaps in three (3) of three (3) ice machines observed on August 22, 2007 between 8:50 AM and 12:30 PM. These findings were acknowledged by Employees #1 and 2 at the time of the observations.	F 465	1. Air Gap completed on ice machines in kitchen and 1 <sup>st</sup> floor pantry. 2 <sup>nd</sup> floor machine to be completed. 2. No other ice machines in building. 3. Maintenance aware to check condition of air gap to ensure no blockage on a regular basis. 4. Director of Maintenance shall monitor any repairs to ice machines and oversee the installation of any new machines.	09/07/07 09/12/07 08/24/07 09/07/07 09/07/07
F 492 SS=E	483.75(b) ADMINISTRATION  The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of five (5) contract employees hired in the dietary department within the last three (3) months, it was determined that a criminal background was not completed prior to the date of hire. Additionally, no reference checks from prior employees were completed for Employees D1, D2, D3 and D4.	F 492	1. All current dietary staff records have been reviewed and are in compliance for criminal background check clearance. 2. All new hires will not be processed to start employment without documented criminal background or reference checks on file. 3. The Regional Director of Operations will audit this process monthly for compliance. 4. Employee file documentation has been added to the quarterly QA report.	08/23/2007 08/23/2007 08/23/2007 08/23/2007

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

PRINTED: 08/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/24/2007	
NAME OF PROVIDER OR SUPPLIER  METHODIST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008		
(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 492	<p>Continued From page 7</p> <p>The findings include:</p> <p>According to 22 DCMR 4701.2, " Except as provided in section 4701.6, each facility shall obtain a criminal background check ...before employing or using the contract services of an unlicensed person."</p> <p>A review of the employees hired into the dietary department within the last three (3) months, revealed that four (4) employees date of hire occurred before the criminal background check was completed.</p> <ol style="list-style-type: none"> <li>1. Employee D1's date of hire was June 22, 2007. The criminal background check was completed on June 29, 2007. No reference checks were completed prior to the date of hire.</li> <li>2. Employee D2's date of hire was June 16, 2007. The criminal background check was completed June 18, 2007. No reference checks were completed prior to the date of hire.</li> <li>3. Employee D3's date of hire was June 28, 2007. The criminal background check was completed July 3, 2007. No reference checks were completed prior to the date of hire.</li> <li>4. Employee D4's date of hire was June 28, 2007. The criminal background check was completed July 3, 2007. No reference checks were completed prior to the date of hire. There were no issues identified on any of the criminal background checks reviewed.</li> </ol> <p>A face-to-face interview was conducted with Employee #1 on August 23, 2007 at 11:10 AM. He/she stated, " The background checks are</p>	F 492		

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

PRINTED: 08/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/24/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008</b>		
(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 492	Continued From page 8 done by the corporate office. They tell us if a manager can hire a candidate. It is the responsibility of each facility manager to follow-up with reference checks. I have been here two weeks. I can't tell you why the previous manager did not do reference checks. I don't know why we were told by corporate to hire these people before the background checks were back."	F 492		