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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING ____ B. WING ____	01/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

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F 000	INITIAL COMMENTS	F 000	Please begin typing your responses here:	

INITIAL COMMENTS

A recertification Quality Indicator Survey was conducted on January 22 through January 28, 2014. The deficiencies are based on observation, record review, resident and staff interviews for 38 sampled residents.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:
Abbreviations
AMS - Altered Mental Status
g-tube Gastrostomy tube
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
NP - Nurse Practitioner
BID - Twice- a-day
HVAC - Heating ventilation/Air conditioning
Neuro - Neurological
B/P - Blood Pressure
CRF - Community Residential Facility
EMS - Emergency Medical Services (911)
DMH - Department of Mental Health
Peg tube - Percutaneous Endoscopic Gastrostomy
NP - Nurse Practitioner
BID - Twice- a-day
B/P - Blood Pressure
L - Liter
Dl - deciliter
CMS - Centers for Medicare and Medicaid Services
Lbs - pounds (unit of mass)
MAR - Medication Administration Record
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], LNHA TITLE (X6) DATE 3/7/14

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 000	Continued From page 1 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter POS - physician ' s order sheet Prn - As needed TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia mm/Hg - millimeters of mercury mcg/dl - micrograms per deciliter	F 000		
F 172 SS=D	483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS The resident has the right and the facility must provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);	F 172	F 172 1. Resident #68 was informed of unrestricted visiting hours by the staff on 1/27/14. 2. Current residents/new residents and responsible parties were notified of their right to immediate access to visitors in the nursing facility on an on-going basis. 3. The admissions packet was revised to reflect unrestricted visitation hours on 1/27/14. In-service education was provided for staff regarding Unrestricted visiting hours on 1/27/14. Family members will be informed of unrestricted visiting hours during the Family Council meeting on 3/8/14. 4. Adherence to visitation access for residents and family members will be monitored monthly and reported quarterly to the QAPI Committee. 5. Completion date 3/8/14	3/8/14

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F 172	Continued From page 2	F 172		

The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review for one (1) of 38 sampled residents, it was determined that facility staff failed to promote resident rights as it relates to visiting hours for Resident #68.

The findings include:

Facility staff failed to promote resident rights regarding " reasonable " visitation.

A face-to-face interview was conducted with Resident #68 on January 24, 2014 at approximately 10:30 AM. He/she stated that visiting hours are restricted to the period of 11:00 AM - 8:00 PM. He/she stated that relatives from

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F 172	Continued From page 3 out of town attempted to visit at approximately 10:00 AM during the holiday season. They were not allowed to enter and advised that visiting hours were 11 AM - 8PM. A review of the facility ' s admission packet lacked evidence of resident rights related to visiting hours. A face-to-face interview was conducted with Employees #12 and 13 on January 28, 2014 at approximately 3:30 PM. In response to a query regarding visiting hours, both stated that the resident ' s responsible party must be contacted for approval if a visitor comes outside of the designated hours of 11AM - 8PM. If the resident has a roommate, it must be approved or arrangements must be made to move the resident to a private place. A face-to-face interview was conducted with Employee #1 on January 28, 2014 at approximately 3:45 PM. He/she acknowledged that the visiting hours are not included in the admission packet however, referenced as ' unrestricted ' in the facility ' s " Welcome Book. " He/she further stated that visitation is unrestricted although they recommend the hours between 11 AM - 8 PM. The facility failed to ensure that residents and staff were fully informed regarding unrestricted visiting hours.	F 172		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241	F 241 1. The signage in resident #1's room was removed immediately on 1/27/14. There were no negative outcomes to the resident. 2. All other residents rooms were checked for signage/postings and removed as needed. 3. Educational in-service was provided to all staff on promotion of dignity and respect of individuality related to confidential clinical and personal information. 4. Confidential clinical and personal signage and postings in resident's rooms will be monitored by staff during rounds and reported to QAPI quarterly. 5. Completion date	2/25/13

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F 241	Continued From page 4 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interview for five (5) of 38 sampled residents, it was determined that facility staff failed to promote residents ' dignity as evidenced by the posting of signage that included confidential clinical and/or personal information able to be seen by other residents and/or visitors. Residents #1, 106, 150, 194 and 196 The findings include: 1. Facility staff failed to promote dignity for Resident #1 as evidenced by the posting of signage that identified the resident ' s personal information that was visible to other residents and/or visitors. An observation of Resident #1 ' s room on January 27, 2014 at approximately 3:00 PM revealed a sign posted on the wall above the head of the bed that read, " Please look for my dentures. " A picture of teeth was observed on the sign. The observation was made in the presence of Employee #3 who acknowledged the findings and removed the signage. 2. Facility staff failed to promote dignity for Resident #106 as evidenced by the posting of signage in his/her room that included confidential clinical information that was visible to other	F 241	Finding #2 1. The confidential clinical information posted in resident #106's room was removed immediately on 1/27/14. There were no negative outcomes to the resident. 2. All other resident rooms were checked. There were no other confidential clinical information found in the other resident rooms. 3. Educational in-service was provided to all staff on promotion of dignity and respect of individuality related to confidential clinical and personal information. 4. Confidential clinical and personal signage and postings in resident's rooms will be monitored by staff during rounds and reported to QAPI monthly. 5. Completion date	2/26/14

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F 241	Continued From page 5 residents and/or visitors. An observation of Resident #106 ' s room on January 23, 2014 at approximately 12:30 PM revealed a sign posted on the wall that included a documented record of the resident ' s blood glucose results and prescribed insulin orders. A face-to-face interview was conducted with Employee #3 on January 27, 2014 at approximately 11:45 AM. He/she acknowledged the posted signage and stated that the resident wanted to see his/her blood sugar ranges and insulin coverage that was ordered. The interdisciplinary team decided to post the data on the resident ' s wall near the window to encourage the resident ' s compliance with the treatment. The sign was subsequently removed. Facility staff failed to ensure that Resident #106 ' s dignity was maintained by the posting of confidential clinical information that was visible to others. 3. Facility staff failed to promote dignity for Resident #150 as evidenced by the posting of signage that identified the resident ' s name and personal information that was visible to other residents and/or visitors. During the survey period of January 22 through 28, 2013 a sign was observed posted on the wall at the third (3rd) floor nursing station that read: " Attention nurses!!! The following Medicare Part A resident must be documented on every shift (AM, PM, & NOC) ...[sic]. " Resident #150 ' s name was listed on the signage as item numeral one (1).	F 241	Finding #3, 4 and 5 1. The confidential clinical information for residents #150, 194 and 196 posted at the nursing station on the 3rd floor were removed immediately on 1/27/14. There were no negative outcomes to the residents identified. 2. All other nursing stations were checked for any posted/confidential clinical information. No other confidential clinical information was noted to be posted on other nursing stations. 3. Educational in-service was provided to all staff on promotion of dignity and respect of individuality related to confidential clinical and personal information. 4. Confidential clinical and personal signage and postings in resident's rooms will be monitored by staff during rounds and reported to QAPI monthly. 5. Completion date	2/26/14

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F 241	Continued From page 6	F 241		

The findings were acknowledged during a face-to-face interview with Employee #1 on January 28, 2014 at approximately 1:00 PM.

4. Facility staff failed to promote dignity for Resident #194 as evidenced by the posting of signage that identified the resident ' s name and personal information that was visible to other residents and/or visitors.

During the survey period of January 22 through 28, 2013 a sign was observed posted on the wall at the third (3rd) floor nursing station that read: " Attention nurses!!! The following Medicare Part A resident must be documented on every shift (AM, PM, & NOC) ...[sic]. " Resident #194 ' s name was listed on the signage as item numeral two (2).

The findings were acknowledged during a face-to-face interview with Employee #1 on January 28, 2014 at approximately 1:00 PM.

5. Facility staff failed to promote dignity for Resident #196 as evidenced by the posting of signage that identified the resident ' s name and personal information that was visible to other residents and/or visitors.

During the survey period of January 22 through 28, 2013 a sign was observed posted on the wall at the third (3rd) floor nursing station that read: " Attention nurses!!! The following Medicare Part A resident must be documented on every shift (AM, PM, & NOC) ...[sic]. " Resident #196 ' s name was listed on the signage as item numeral three (3).

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F 241	Continued From page 7 The findings were acknowledged during a face-to-face interview with Employee #1 on January 28, 2014 at approximately 1:00 PM.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations and interview for one (1) of 38 sampled residents, it was determined that facility staff failed to assist Resident #83 to exercise personal preference as evidenced by failing to allow the resident an opportunity to be seated in the common area when desired. Resident #83 The findings include: On January 23, 2014 at approximately 10:45 AM, Resident #83 was observed seated in a recliner geriatric chair in his/her room behind the drawn curtain. The resident responded affirmatively in a very soft tone to a request for entry into his/her room. The resident was observed with a Gastrostomy tube attached to an enteral feeding that was infusing via infusion pump. Resident #83 had a grimace on his/her face. In	F 242	1. Resident #83 was immediately moved to the common area as desired on 1/27/14. There were no negative outcomes to the resident. 2. All other residents in their rooms were asked if they wished to be in the common area. No other resident verbalized desire to be moved to the common area. 3. Educational in-service was provided to all staff on Adherence to Resident Personal Preference, Resident Right to Choose Activities, Schedules and Health Care Consistent with His or Her Care Plan on 3/5/14. 4. Resident Right to Choose Activities, Schedules and Health Care Consistent with Plan of Care will be monitored every shift and reported monthly. 5. Completion date 3/5/14	3/5/14

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F 242	Continued From page 8 response to a query whether or not he/she was uncomfortable, he/she nodded " no. " In response to a query regarding plans for the morning, Resident #83 responded affirmatively to a desire to leave the room and sit in the common area [day room] in the company of others. An interview was conducted with the resident ' s assigned nurse, Employee #11 following the interaction with Resident #83. Employee #11 was informed that Resident #83 expressed a desire to be seated out of his/her room into the common area. Employee #11 stated that the resident would need to wait until the afternoon once his/her enteral feeding was complete because there was no place in the day room to plug the infusion pump. He/she added that resident ' s geriatric chair would obstruct the passageway if plugged into the outlet along the corridor in the common area. Facility staff failed to assist Resident #83 to fulfill his/her choice to be seated in the common area in the company of others. The findings were acknowledged during a face-to-face interview with Employee #5 on January 23, 2014 at approximately 3:00 PM. However, Employee #5 stated that there were accommodations available in the day room for Resident #83 and that staff would be educated.	F 242		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for one (1) of 38 sampled residents, it was

F 272

1. The identified MDS for Resident #1 was corrected to reflect the CAAS information and resubmitted on 3/6/15
2. Other residents' MDS were checked for accuracy of CAAS and corrections made as required.
3. MDS Coordinators were provided educational in-service on Accurate Coding and Importance of CAAS on 3/3/14
4. Director of Nursing will monitor accuracy of coding including CAAS and report to QAPI monthly.
5. Completion date 3/6/14

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determined that facility staff failed to identify the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A] for Resident #1.

The findings include:

According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, indicate the date and location of the CAA documentation...CAA documentation should include information on the complicating factors, risks and any referrals for the resident for this care area ... "

A review of Resident #1 ' s annual Minimum Data Set dated October 2, 2013 revealed that Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss, #4 Communication, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence / Catheter, #7 Psychosocial Well-Being, #10 Activities, 11 Falls, #12 Nutrition, #15 Dental, and #16 Pressure Ulcers.

The record revealed that the location and date of CAA information [for care areas #2, 4, 5, 6, 7, 10, 11, 12, and 16] was recorded as " CAA 3.0 10/07/2013. "

There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found.

The clinical record lacked evidence of

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F 272	Continued From page 11 documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #9 on January 28, 2014 at approximately 2:20 PM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed January 28, 2014.	F 272		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 12	F 329	F 329 – Finding #1 1. Resident #23 was assessed on 2/1/14. No adverse effect was noted. Resident was seen by psychiatrist, Seroquel dose reduced from 50 mg to 25 mg at bedtime on 3/5/14. 2. Records of all other residents on antipsychotic medication were reviewed for pharmacist recommendation for Gradual Dose Reduction and referred to physician as needed. 3. In-service education on Gradual Dose Reduction provided to licensed staff on 3/5/14. 4. Residents on antipsychotic medications will be monitored for pharmacy recommendations for gradual dose reduction and reported to QAPI quarterly. 5. Completion date 3/5/14	3/5/14

This REQUIREMENT is not met as evidenced by:

Based on observations, record review and interview for two (2) of 38 sampled residents, it was determined that facility staff failed to attempt gradual dose reduction (GDR) for the use of antipsychotic medications. Residents #23 and 148.

The findings include:

1. Facility staff failed to ensure that gradual dose reduction [GDR] was attempted for the use of the antipsychotic medication, Seroquel for Resident #23.

A review of physician ' s orders signed January 8, 2014 revealed Resident #23 ' s medication regimen included Seroquel 25mg daily at 10 AM and 50mg daily at bedtime for Psychosis. The medication was originally prescribed May 8, 2010.

A review of physician ' s orders for the period of January 1, 2013 to January 8, 2014 (present) lacked evidence of an attempt of gradual dose reduction for Seroquel.

Resident #23 was observed drowsy and/or sleeping in the day room on the following dates during the survey period: January 22, 2014 at 11:30 AM; January 23, 2014 at 9:30 AM and January 27, 2014 at 10:00 AM.

A review of Resident #23's daily " Behavior and

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Mood " records for the period of August 2013 through January 2014 were recorded as " behavior, none noted. "

A face-to-face interview was conducted with Employee #4 on February 27, 2014 at approximately 3:00 PM. He/she stated that the psychiatrist was consulted for GDR but did not recommend a modification of Resident #23 ' s Seroquel.

Resident #23 exhibited signs of lethargy, no evidence of adverse behaviors and was continued on antipsychotic medication without a clear indication to warrant its continued use. There was no evidence of an attempt of gradual dose reduction for Seroquel. The record was reviewed January 27, 2014.

2. Facility staff failed to ensure that gradual dose reduction [GDR] was attempted with timeliness for the use of antipsychotic medication, Zyprexa for Resident #148.

A review of physician ' s orders revealed that Resident #148 was prescribed the antipsychotic medication, Zyprexa for psychosis.

An interim physician ' s order dated October 2, 2013 at 4:20 PM directed; " Psych consult due to psychotropic use and [diagnosis] of psychosis. "

An interim physician ' s order dated October 3, 2013 directed; " [Decrease] Zyprexa to 7.5mg po QHS (by mouth at hour of sleep). "

According to the pharmacy " Drug Regimen Review " the following was revealed:

Finding #2

1. Gradual Dose Reduction was not done as per pharmacist recommendations. Zyprexa was reduced on 10/3/13. Resident was assessed on 1/28/14. There was no negative outcome to the resident.
2. Records of all residents on antipsychotic medication were reviewed for pharmacists recommendations for Gradual Dose Reduction and referred to physician as needed.
3. In-service education on Gradual Dose Reduction was provided to licensed nurses on 3/5/14.
4. Residents on antipsychotic will be monitored monthly for pharmacy recommendation for gradual dose reduction and reported to QAPI quarterly.
5. Completion date: 3/5/14

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January 21, 2013- " As above " , reference to note dated November 8, 2012- SPP {Significant Potential Problem) - Gradual Dose Reduction - Olanz 10 mg bid. "

February 20, 2013- Same as above

March 20, 2013- No potential problem

April 20, 2013- Psych diagnosis

May 10, 2013- Significant Potential Problem- GDR- Zyprexa

June 14, 2013- As above (Zyprexa)

July 2013- Significant Potential Problem - Zyprexa

August 2013- Zyprexa; MD {Medical Doctor) does not want

September 2013- Zyprexa- Significant Potential Problem

October 2013- Significant Potential Problem- Zyprexa. "

According to a " Psychiatric Evaluation." dated October 3, 2013; " Recommendations: [Decrease] Zyprexa to 7.5mg po [by mouth] QHS (at hour of sleep) at this time with later discontinuation because of " Black Box Warning " for Zyprexa in the elderly dementia [with] psychosis. "

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F 329	Continued From page 15 The clinical record lacked evidence that a gradual dose reduction for the psychotropic medication was attempted in a timely manner. A period greater than nine (9) months [January to October 2013] lapsed before the pharmacist ' s recommendation for gradual dose reduction was attempted. A face-to-face interview was conducted with Emptoyee #3 on January 28, 2014 at approximately 12:45 PM. When queried; " Why was there a delay in psychiatry evaluating the resident for a gradual dose reduction; he/she responded, " We called the psych doctor multiple times; however, [he/she] did not come in to see the resident. " Facility staff failed to attempt gradual dose reduction in a timely manner for the antipsychotic medication prescribed for Resident #148. The clinical record was reviewed on January 28, 2014.	F 329	F 364 1. Resident # 68, 106 and 154 were assessed on 1/23/14. No corrective action could be done for the residents identified during this timeframe. There were no negative outcomes to residents. 2. All the appropriate residents were assessed and interviewed by dietary staff regarding their satisfaction of hot food being served on 1/23/14 and the residents did not complain about the food temperature. 3. In-service education were provided to the Dietary Department staff regarding required regulatory guidelines for Food Temperatures. Steam tables temperatures were adjusted to ensure compliance with proper hot food temperature. 4. Food temperatures for residents will be monitored through resident interviews and test trays monthly and reported to QAPI quarterly. 5. Completion date:	3/8/14
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on three (3) of 38 resident interviews and test tray observations on two (2) of three (3) residential units, it was determined that facility	F 364		

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staff failed to serve hot foods at preferable temperatures. Residents #68, 106 and 154

The findings include:

Three (3) of 38 sampled residents communicated that meals were not served at the proper temperature as follows:

During a face-to-face resident interview on January 23, 2014 at approximately 9:00 AM; in response to the question, " Is the food [hot food] served at the proper temperature? " Resident #68 replied " Breakfast is always cold. "

During a face-to-face resident interview on January 23, 2014 at approximately 10:45 AM; in response to the question, " Is the food [hot food] served at the proper temperature? " Resident #106 replied " My food is cold every day. "

During a face-to-face resident interview on January 23, 2014 at approximately 3:00 PM; in response to the question, " Is the food [hot food] served at the proper temperature? " Resident #154 replied " most of the time, food is cold. "

Food temperatures were tested on January 23, 2014 at approximately 12:15 PM during the lunch meal service by way of " test tray " on the second and third floors. Hot food temperatures were measured at temperatures less than 140 degrees Fahrenheit as follows:

	Second floor	Third floor
Liver and Onions	122 degrees F	

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F 364	Continued From page 17 117 F Mashed potatoes 126 F 135 F Collard Greens 115 F 130 F Puree Greens 153 F 139.8 F Puree Meat 125 F 126 F Facility staff failed to serve hot foods at preferable temperatures as evidenced by resident interview and observation via " test tray. " The test tray observations were made in the presence of Employee #10 on January 23, 2014 who acknowledged the findings.	F 364	F371 1. The dietary staff stacked wet utensils on a storage rack that did not meet regulatory guidelines. Four (4) six-inch half pans, seven (7) two-inch one-third pans, eleven (11) four-inch one quarter pans and five (5) one-half sheet pans were removed from storage racks on 1/22/14. All above utensils were washed again per regulatory guidelines and placed on dry rack surface until utensils were completely dry. The dried utensils were then placed on the storage rack. 2. There were no other dishes/utensils observed in similar condition. 3. In-services were provided to the Dietary Department staff regarding Sanitation/preparation and Storage of Utensils per Regulatory Guidelines. 4. Sanitation and Storage of Dietary Utensils will be monitored and reported to the QAPI Committee quarterly. 5. Complete date:	3/8/14
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on January 22, 2014 at approximately 2:15 PM, it was determined that the facility failed to store food	F 371		

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F 371	Continued From page 18 utensils under sanitary conditions as evidenced by four (4) of four (4) six-inch half-pans, seven (7) of seven (7) two-inch one-third pans, 11 of 11 four-inch one-quarter pans and five (5) of five (5) one-half sheet pans that were stacked wet on a storage rack. Based on observations made on January 22, 2014 at approximately 2:15 PM, it was determined that the facility failed to store food utensils under sanitary conditions as evidenced by four (4) of four (4) six-inch half-pans, seven (7) of seven (7) two-inch one-third pans, 11 of 11 four-inch one-quarter pans and five (5) of five (5) one-half sheet pans that were stacked wet on a storage rack. The findings include: 1. Four (4) six-inch half-pans, seven (7) two-inch one-third pans, 11 four-inch one-quarter pans and five (5) one-half sheet pans stored wet. These observations were made in the presence of the Director of Food Services who acknowledged the findings.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office;	F 412		

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F 412	Continued From page 19 and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 38 sampled residents, it was determined that facility staff failed to follow through on determining eligibility for dentures for Resident #1. The findings include: A face-to-face interview was conducted with Resident #1 on January 22, 2014 at approximately 4:30 PM. The resident was observed edentulous. When the resident was queried, " Do you have any chewing or eating problems (could be due to: no teeth, missing teeth, oral lesions, broken or loose teeth)? " He/she replied; " Yes, they were supposed to be giving me dentures a long time ago. " A review of Resident #1 ' s clinical record revealed " dental history and record of consultations " as follows: June 26, 2012- " Took face sheet for FU/FL [For upper/for lower] denture eligibility. " August 6, 2013- Oral Assessment. " The clinical record lacked evidence that follow up was conducted regarding obtaining dentures for Resident #1. The record lacked evidence that the resident sustained any unplanned weight loss.	F 412	1. Resident #1 was assessed and there was no evidence of adverse effect including unplanned weight loss. The dentist was notified on 2/9/14 and referred for denture assessment. 2. All edentulous residents were assessed to determined eligibility for dentures, consults were done as needed. 3. In-service education on eligibility referral for dental evaluation provided to all licensed staff on 3/5/14 4. Residents will be monitored for dental needs and reported to QAPI monthly. 5. Completion date;	3/8/14

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A face-to-face interview was conducted with Employee #3 on January 27, 2014 at approximately 10:00 AM. He/she acknowledged being aware that the resident did not have dentures. He/she added; the dentist will be here on tomorrow (Tuesday, January 28, 2014) and he/she will be evaluating the resident.

A follow-up review of the dental assessment revealed; " January 28, 2014- Took face sheet again for FU/FL]. I don ' t have record of [June 26, 2012] but will record ... " The record was reviewed on January 28, 2014.

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON — F 428

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for one (1) of 38 sampled residents, it was determined that the facility staff failed to act upon reported irregularities from the Medication Regimen Reviews (MRR) by the pharmacist for Resident #154.

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F 428	Continued From page 21 The findings include: 1. The facility staff failed to act upon reported irregularities from the Medication Regimen Reviews (MRR) by the pharmacist for Resident #154. A " Physician ' s Order " signed and dated November 26, 2013 directed: " Lab HgB A1c (Glycosylated hemoglobin) q[every] 3 months 4th Wed [Wednesday] November/ February/ May/ August NOC [nocturnal (overnight) shift Recurring lab start date 11/27/2013 reason: Diabetes Mellitus" A review of the lab report dated November 27, 2013 revealed a result that read, "Hemoglobin A1c PENDING " The MRR [" Medication Regimen Review "] recorded by the pharmacist on December 9, 2013, read: NPP (No Potential Problem) - A1c pending. " The MRR dated January 20, 2014, the Pharmacist wrote, " SPP (Significant Potential Problem) A1c? " There was no evidence that the pharmacist ' s January 20, 2014 report of irregularity was addressed. A face-to-face interview was conducted with Employee #5 on January 28, 2014 at approximately 12:15 PM. A query was made regarding whether the pharmacist ' s MRR was addressed. Employee #5 called the lab and was unable to obtain the results of the HGB A1C. Employee #5 acknowledged that there was no evidence that the pharmacist ' s MRR was	F 428	1. Resident #154's physician was notified. Hgb A1C was drawn on 2/26/14. There was no negative outcome for resident. Results were within normal limits. 2. All other resident records were reviewed for pharmacy medication regimen review. Physician notified for follow up as needed. 3. In-service provided to licensed nurses on the importance of follow through on Medication Regimen Review on 2/28/14. 4. Follow through on MMRs will be monitored monthly and reported to QAPI quarterly. 5. Completion date:	3/8/14

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F 428	Continued From page 22 addressed or acted upon. The record was reviewed on January 28, 2014.	F 428		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD 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 three (3) of 38 sampled residents, it was determined that facility staff failed to prescribe nurse pronouncement directives consistent with the District ' s law. Residents 118, 124, 181. The findings include: Pursuant to District of Columbia District of Columbia Law 4-34; D.C. Code §6-201; Act 9-299, Section 2, "To amend the Vital Records Act of 1981 to provide that the certificate of death shall contain a pronouncement of death section separate from the medical certification of cause of death section ...to authorize a funeral director to remove a decedent ' s remains following a medically expected death on the authority of a pronouncement of death signed by an attending registered nurse or treating physician ... " Section 2 paragraph (4A) " Expected death " means a death from a previously diagnosed illness with a prognosis of death in less than 6	F 492		

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F 492	Continued From page 23 months... " 1. A review of the medical record for Resident #118 revealed the medical practitioner failed to prescribe nurse pronouncement directives consistent with District of Columbia Law 4-34; D.C. Code §6-201; D.C. Act 9-299; Section 2, " Expected Death ... " Interim orders signed by the nurse practitioner directed: " DNR/DNI [don not resuscitate or intubate]; No hospitalization, no labs, no IV [intravenous] fluids, no weights; RN Pronouncement. " The orders and/or medical team progress notes lacked evidence that the resident ' s illness included a prognosis of death in less than 6 months. A review of Section J1400, Prognosis, of the quarterly Minimum Data Set dated October 15, 2013 was coded as " no " in response to the question of life expectancy of less than 6 months. There was no evidence that the medical team prescribed nurse pronouncement directives in accordance with state law. The record lacked evidence of expected death for Resident #118. The record was reviewed January 27, 2014. 2. A review of the medical record for Resident #124 revealed the medical practitioner failed to prescribe nurse pronouncement directives consistent with District of Columbia Law 4-34:	F 492	1. Medical record of Resident #118, #124, #181 were amended to reflect compliance with DC Law 4-34 on nurse pronouncement to include resident's illness and prognosis of death with 6 months. 2. All other resident records with orders for RN pronouncement were reviewed and new orders written to reflect compliance with DC Law 4-34 on nurse pronouncement on 1/31/14 to include resident illness and prognosis of death within 6 months. 3. In-service education was provided to licensed staff regarding DC Law 4-34, nurse pronouncement. Policy on RN pronouncement was revised to reflect need to include residents illness and prognosis of death within 6 months. 4. Nurse pronouncement orders will be monitored by licensed nurses and reported to QAPI quarterly. 5. Completion date	1/31/14 2/28/14 2/28/14

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D.C. Code §6-201, D.C. Act 9-299; Section 2, " Expected Death ... "

Interim orders signed by the nurse practitioner directed: " DNR/DNI [don not resuscitate or intubate]; No hospitalization, no labs, no IV [intravenous] fluids, no weights; RN Pronouncement. "

The orders and/or medical team progress notes lacked evidence that the resident ' s illness included a prognosis of death in less than 6 months.

A review of Section J1400, Prognosis, of the admission Minimum Data Set dated November 20, 2013 was coded as " no " in response to the question of life expectancy of less than 6 months.

There was no evidence that the medical team prescribed nurse pronouncement directives in accordance with state law. The record lacked evidence of expected death for Resident #124. The record was reviewed January 27, 2014.

3. A review of the medical record for Resident #181 revealed the nurse practitioner failed to prescribe nurse pronouncement directives consistent with District of Columbia Law 4-34; D.C. Code §6-201, D.C. Act 9-299; Section 2, " Expected Death ... "

Interim orders prescribed by the nurse practitioner dated January 16, 2014 at 2PM directed: " DNR/DNI [don not resuscitate or intubate]; No hospitalization, no labs, no IV

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F 492	Continued From page 25 [intravenous] fluids, no weights; RN Pronouncement. " The orders and/or medical team progress notes lacked evidence that the resident ' s illness included a prognosis of death in less than 6 months. A review of Section J1400, Prognosis, of the admission Minimum Data Set dated October 2, 2013 was coded as " no " in response to the question of life expectancy of less than 6 months. There was no evidence that the medical team prescribed nurse pronouncement directives in accordance with state law. The record lacked evidence of expected death for Resident #181. The record was reviewed January 24, 2014.	F 492		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. This REQUIREMENT is not met as evidenced	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	01/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(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 514	Continued From page 26	F 514		

by:
Based on observation, record review and interview for two (2) of 38 sampled residents, it was determined that the dentist failed to record an assessment and plan of care for one (1) resident observed with broken teeth and licensed staff failed to sign and date the dialysis communication logs for one (1) resident. Residents #18 and 41.

The findings include:

1. An observation of Resident #18 on January 22, 2014 at approximately 3:30 PM revealed the resident had broken teeth that appeared to have plaque residue on the surface.

In response to a query regarding whether or not he/she received assistance with brushing teeth, Resident #18 stated " I brush them myself ...they get my toothbrush for me. " The resident replied " no " when asked if he/she had any teeth pain or oral problems.

A review of dental examination progress notes in the clinical record revealed the most recent dental examination was May 28, 2013. The dentist recorded " Oral assessment " in the progress note section of the dental examination. There was no further evidence of documentation related to the oral examination for May 28, 2013.

The dentist failed to record a dental assessment and plan of care for Resident #18 ' s oral health.

The findings were acknowledged during a face-to-face interview with Employee #4 on January 27, 2014 at 4:00 PM. The record was

1. The dentist for resident #18 was notified regarding need for oral assessment. Dentist visited resident on 2/4/14 but resident declined oral assessment.
2. All other resident charts were reviewed for evidence of oral assessment On 2/4/14. All other residents had documentation of comprehensive oral assessment.
3. Educational in-service provided to the dentist by the medical director regarding documentation of oral assessment and plan of care. Oral assessment form was reviewed and revised on 3/4/14.
4. Comprehensive dental assessment documentation will be monitored monthly and reported to QAPI quarterly.
5. Completion date:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 514	Continued From page 27 reviewed January 24, 2014. 2. Facility staff failed to sign and date dialysis communication logs for Resident #41. A review of the dialysis communication log records revealed that on March 16, 2013, April 2, 2013, April 4, 2013, April 13, 2013, and September 19, 2013 the Charge Nurse/Team Leader failed to date and record a signature in the allotted space. The space designated for signature and date remained blank. A face-to-face interview was conducted on January 27, 2014 at approximately 10:00AM with Employee # 5. After reviewing the dialysis communication logs, he/she acknowledged the findings. The record was reviewed on January 27, 2014.	F 514	1. Resident #41 – Communication log was reviewed, signed and dated as needed, 2. There are no other residents on dialysis in the facility. 3. In-service education was provided to licensed nurses regarding accurate notation on dialysis communication log. 4. Dialysis communication log will be monitored by Director o Nursing monthly and reported to QAPI quarterly. 5. Completion date	1/27/14 3/8/14