Received DOH 4/28/06

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

PRINTED: 04/18/2006
FORM APPROVED
OMB NO. 0938-0391

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 _____	03/30/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A certification survey was conducted from March 28 through March 30, 2006. The following deficiencies are based on observation, staff and resident interviews and record review. The sample included 25 residents with one (1) supplemental resident based on a census of 161 the first day of survey.	F 000	Preparation and/or execution of this Plan of Correction do not constitute admission or agreement by the provider of the truth of the facts alleged or concluded in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of Federal and State laws require it.	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or 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 observation, record review and staff interview for one (1) of 25 sampled residents, it was determined that facility staff failed to respond to a resident ' s call light promptly according to the facility policy. Resident # 14. The findings include: According to the facility ' s policy titled, "Call light, NO 99C - 001, page 53, issuing department nursing, Objective: 1. To respond to resident ' s request and needs. 2. To provide a sense of security to residents who are dependent upon staff to met basic needs. Procedure 1. Answer light promptly. " The surveyor observed Resident #14 on March 28, 2006 at 3:15 PM in bed with the lights turned off and the air conditioning unit blowing cold air.	F 241	The responses to the deficiencies in the Plan of Correction will be answered in the following numerical sequence: 1. How will the corrective actions be accomplished for those residents found to have been affected by the deficient practice? 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not occur. 4. How do you plan to monitor your performance to make sure that solutions are sustained? 5. When will corrective action be completed?	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4-28-06

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 241	Continued From page 1 The resident had on a thin hospital gown and was partially covered with a blanket. She/he complained of being cold and wanted to be turned. The resident pressed the call light and a staff member answered at the nursing station, " Can I help you? " The resident responded, " I need to be turned. " The call light was turned off at the nursing station. The surveyor waited 15 minutes but no staff came to help the resident. The surveyor left the room and went to the nursing station and observed four (4) Certified Nursing Assistants at the nursing station discussing the work schedule for the evening shift. A face-to-face interview was conducted with the acting Resident Care Coordinator on March 30, 2006 at 10:00 AM. He/she acknowledged that the staff should have responded to the residents ' s call light promptly.	F 241	F241 Resident #14 1. The resident was turned and given a robe and additional blankets to promote comfort on 3/28/06. 2. Other residents' call lights were checked and answered in a timely manner. 3. In-services were provided to the nursing staff regarding answering call lights in a timely manner on 4/20, 4/21, and 4/22 by the Clinical Care Coordinator and the Nursing Supervisors. Attachment A 4. Response to residents' call lights will be monitored monthly/ quarterly Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 4/26/06.	3/28/06 3/29/06 4/20, 4/21, and 4/22 Monthly Quarterly On-going 4/26/06
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: abundance of personal items and furnishing in residents' rooms, soiled privacy curtains, and	F 253		

Revised 5/23/06 BS

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F 253	Continued From page 2 marred entrance and bathroom doors. These findings were observed in the presence of the Nursing, Housekeeping and Maintenance Services. The findings include: 1. An abundance of personal items such as clothing, towels, diapers and pads on furnishings, paper bags on the floor and extra furnishings were occupying space next to the residents' beds in room 115 in one (1) of 15 observations at 3:22 PM on March 28, 2006 and room 232 in one (1) of 12 observations at approximately 11:15 AM on March 29, 2006. 2. Privacy curtains in residents' rooms were observed to be soiled and stained in the following areas: First Floor Rooms 101, 108, 115 and 127 in four (4) of 15 observations between 10:54 AM and 4: 05 PM on March 28, 2006. Third Floor Rooms 312, 320, 321, 325 and 328 in five (5) of 11 observations between 3:30 PM and 4:10 PM on March 29, 2006 and 8:53 AM and 9: 15 AM on March 30, 2006.	F 253	F253 Finding #1 1. Resident's family was notified on several occasions to come to facility to assist with the removal of unused personal items and clutter. Resident has been of the need to limit personal items in the room for safety reasons. 2. All residents rooms were checked to identify rooms with abundance of personal items that could potentially compromise safety. 3. Met with nursing and other support staff (recreation, therapy, housekeeping) to inform of procedure to be followed when resident's room have an excess of personal items that affect safety. This issue will also be presented to responsible family members at next Resident Council and Family Council meeting. 4. Spot room checks will be done weekly during rounds. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 4/29/06	3/30/06 4/26/06 4/29/06 Monthly Quarterly on-going 4/29/06

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483 .10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 25 sampled residents, it was determined that facility staff failed to develop a care plan with goals, approaches and interventions for communication for Resident #21 . The findings include: Resident #21 was admitted to the facility on August 15, 2005. The admission Minimum Data Set (MDS) dated August 25, 2005 coded in	F 279	F279 Resident #21 1. The resident's care plan was updated to reflect communication interventions on 3/29/06. 2. Other residents care plans were checked and corrected as required. 3. The Clinical Care Coordinator provided in-services to the Resident Care Coordinators, the Nursing Supervisors and the Care Plan Team members regarding current care plans on 4/20, 4/21 and 4/22/06. Attachment D 4. Residents' care plans will be monitored monthly/quarterly. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 4/26/06.	3/29/06 4/26/06 4/20, 4/21 and 4/22 Monthly Quarterly on-going 4/26/06

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on the review of the clinical record for one (1) of one (1) resident receiving hospice services, it was determined that facility staff failed to develop an interdisciplinary care plan to include hospice care. Resident #16. The findings include: During the review of the clinical record for Resident #16, a physician's orders dated February 28, 2006 directed, "Pt. (Patient) is DNR (Do Not Resuscitate). RN pronouncement. Palliative care by hospice [name]." On March 4, 2006 "Begin hospice care here at [name] facility	F 280	F280 Resident #16 1. The resident's care plan was reviewed by nursing and Hospice services on 4/4/06. 2. All residents checked, there were no other residents are currently on hospice. 3. In-services were conducted with hospices team and Interdisciplinary Team members on 4/20, 4/21 and 4/22/06. Attachment E 4. Residents receiving hospice services will be monitored monthly and quarterly through CQI. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 4/24/06.	4/4/06 4/4/06 4/20, 4/21 and 4/22 Monthly Quarterly On-going 4/24/06

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F 280	Continued From page 6 with [providers' name]." A care plan was initiated by the facility for hospice care on March 7, 2006. The resident's care plan was last reviewed by facility staff on February 14, 2006. There were no further entries noted for the resident's interdisciplinary care plan . There was no evidence that the facility integrated care with the hospice service. The record was reviewed on March 29, 2006.	F 280	F309 Resident #13 1. The attending physician for resident #13 was notified on 3/30/06. No new orders were obtained from attending physician. The resident was assessed on 3/30/06. Assessments were within normal limits. 2. Other residents with physician orders for anti-hypertensive medication with parameters were checked for accuracy of administration. No other residents were found affected. 3. The Clinical Care Coordinator conducted in-services for Management of Anti-hypertensive Medications to all licensed staff on 4/20, 4/21 and 4/22/06. Attachment F 4. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 4/24/06.	3/30/06 4/20/06 4/20, 4/21, and 4/22/06 Monthly Quarterly 4/24/06
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for two (2) of 25 sampled residents, it was determined that the licensed staff failed to: administer an antihypertensive medication according to the physician's order for one (1) resident and notify the physician of elevated blood glucose for one (1) resident. Residents #13 and JKG1. The findings include: 1. Facility staff failed to administer an antihypertensive medication to Resident #13 as	F 309		

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F 309	Continued From page 7 per physician's orders. A physician's original order dated March 8, 2005 and renewed monthly was a follows: "Toprol XL 25 mg one tablet by mouth everyday for Hypertension. *Hold for systolic blood pressure less than 120 or pulse less than 50." The Medication Administration Record (MAR) listed administration of Toprol XL when the systolic blood pressure was below 120 as follows: February 21, 2006 116/66 January 15, 2006 116/50 January 11, 2006 108/64 December 26, 2005 118/60 December 7, 2005 118/67 The licensed staff failed to withhold the administration of Toprol XL according to the physician's order. The record was reviewed March 28, 2006. 2. Facility staff failed to notify the physician when Resident JKG1 ' s blood sugar was elevated. A review of Resident JKG1's record revealed a physician's order dated May 23, 2005, renewed every 30 days, most recently March 19, 2005 directed, "Insulin Human Regular ...three times per day at 6AM, 12 PM and 4 PM ...for (blood glucose) greater than 301 = (give) 7 units call MD." A review of the March 2006 MAR revealed the following blood glucose levels elevated above 301: March 4, 2006 at 4:00 PM 320	F 309	F 309 Resident JKG1 1. The attending physician for resident #JKG1 was notified on 3/30/06. No new orders were obtained from attending physician. The resident was assessed on 3/30/06. Resident assessments were within normal limits. 2. Other residents orders for insulin with sliding scale parameters were checked for accuracy of administration. No residents were affected. 3. The Clinical Care Coordinator conducted in-services for Management of Residents on Insulin with Slide Scare to all licensed staff on 4/20, 4/21 and 4/22/06. Attachment G 4. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 4/26/06.	3/30/06 4/20/06 4/20, 4/21, and 4/22/06 Monthly Quarterly On-going 4/26/06

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F 309	Continued From page 8 March 8, 2006 at 6:00 AM 353 March 19, 2006 at 6:00 AM 358 March 19, 2006 at 12:00 PM 320 March 25, 2006 at 6:00 AM 351 There was no evidence in the clinical record that the physician was notified of the above cited elevated blood glucose levels. There was no evidence in the clinical record that the resident experienced any symptoms of hyperglycemia. The record was reviewed March 30, 2006.	F 309	F323 Finding #1 1. The four acetylene tanks found in the boiler room were removed, placed in the maintenance storage area, and secured. 2. Residents were monitored for any result of injury or illness due to the area listed. There were no reports or concerns shared during this observation period. 3. Maintenance will maintain all acetylene tanks in a secure and safe environment. 4. Spot check of boiler room will be made during weekly rounds Any trends/issues will reported to the CQI Committee quarterly. The CQI committee will make recommendations and modifications to program if necessary. 5. Completion date 3/30/06	3/30/06 4/12/06 Weekly On-going Weekly On-going Quarterly 3/30/06
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that the facility failed to secure acetylene tanks and provide backing for throw rugs in two (2) residents' rooms. These observations were made in the presence of the Directors of Housekeeping and Maintenance and nursing staff. The findings include: 1. Four (4) acetylene tanks were observed unsecured and stored on the floor near the boilers in the boiler room in four (4) of four (4) observations on March 30, 2006 at 11:00 AM. 2. Throw rugs were observed without backings to	F 323		

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F 323	Continued From page 9 prevent movement in rooms 232 and 304 on March 29, 2006 between 11:00 AM and 3:20 PM.	F 323	F323 Finding #2 1. The floor rugs were removed from room numbers 232 and 304 on 3/30/06. 2. Other residents' room with floor rugs were check and removed as appropriate or as needed. 3. The Clinical Care Coordinator in-serviced regarding Standards for Residents' Rugs on 4/19, 4/20 and 4/21/06. Attachment H 4. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 4/24/06.	3/30/06 3/30/06 4/19, 4/20 and 4/21/06 Monthly Quarterly On-going 4/24/06
F 371 SS=D	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 the dietary tour, it was determined that dietary services were not adequate to ensure that food was prepared in a safe and sanitary manner as evidenced by: soiled cereal bowls and the inner surfaces of the deep fryer. These findings were observed in the presence of the Food Service Director. The findings include: 1. Cereal bowls were observed soiled and stained after washing and ready for reuse in 17 of 80 observations on March 28, 2006 at approximately 2:20 PM. 2. The interior areas of the deep fryer were observed to be soiled with grease on supply lines, electrical wiring and other electrical components on one (1) of one (1) observation on March 28, 2006 at 8:30 AM.	F 371		

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F 323	Continued From page 9 prevent movement in rooms 232 and 304 on March 29, 2006 between 11:00 AM and 3:20 PM.	F 323	F371 Finding #1 1. Identified soiled and stained cereal bowls were discarded on 3/28/06. 2. No residents were affected or harmed by the deficient practice as evidenced by absence of GI illness directly following meals served. 3. The master cleaning scheduled has been revised to include removal of any stained/or soiled cereal bowls as needed. Dietary staff was in-serviced on cleaning cereal bowl properly. 4. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 3/29/06.	3/28/06 3/29/06 3/29/06 Monthly Quarterly on-going 3/29/06
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 prevent movement in rooms 232 and 304 on March 29, 2006 between 11:00 AM and 3:20 PM.	F 323	F371 Finding #2	
F 371 SS=D	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 the dietary tour, it was determined that dietary services were not adequate to ensure that food was prepared in a safe and sanitary manner as evidenced by: soiled cereal bowls and the inner surfaces of the deep fryer. These findings were observed in the presence of the Food Service Director. The findings include: 1. Cereal bowls were observed soiled and stained after washing and ready for reuse in 17 of 80 observations on March 28, 2006 at approximately 2:20 PM. 2. The interior areas of the deep fryer were observed to be soiled with grease on supply lines, electrical wiring and other electrical components on one (1) of one (1) observation on March 28, 2006 at 8:30 AM.	F 371	1. Interior areas of deep fryer soiled with grease were cleaned and corrected. Supply lines, electrical wiring and other components were also cleaned. 2. No resident was affected by this deficient as evidenced by absence of GI illness. 3. The master cleaning schedule has been revised to include cleaning of interior/exterior components of deep fryer. Dietary staff were in-serviced on proper way to clean the deep fryer. 4. The dietary management team will conduct random and weekly spot checks of the deep fryer to assess for compliance. Any trends/issues will be reported to the CQI Committee quarterly. The CQI Committee will make recommendations and modifications to program if necessary. 5. Completion date 3/29/06.	3/28/06 3/29/06 3/29/06 Monthly Quarterly on-going 3/29/06

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 _____	03/30/2006

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F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on an observation during the environmental tour, it was determined that facility staff failed to properly store toilet plungers. This observation was made in the presence of the Directors of Housekeeping and Maintenance and nursing staff. The findings include: Two (2) toilet plungers were observed stored on the floor of the bathroom in a resident's room, # 102, in one (1) of 15 observations on March 28, 2006 at approximately 11:00 AM.	F 441	F441 Resident Room #102 1. The toilet plunger was removed from resident room #102 on 3/30/06. 2. Other resident's bathrooms were checked for toilet plungers and corrected if required. 3. The Clinical Care Coordinator facilitated an in-service on Infection Control for nursing staff on 4/19, 4/20 and 4/21/06. Attachment I 4. Any trends/issues will be reported to CQI Committee quarterly. The CQI Committee will make recommendations to program if necessary. 5. Completion date 4/24/06.	3/30/06 3/30/06 4/19, 4/20 and 4/21/06 Monthly Quarterly On-going 4/24/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 492 SS=D	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 observation, staff interview and record review, it was determined that two (2) physicians failed to maintain current credentials at the facility. Physicians #1 and #2. The findings include: A review of the physicians' licenses maintained by the facility revealed that Physician #1 had a District of Columbia Controlled Substance license with an expiration date of September 30, 2005. Physician #2 had a Drug Enforcement Agency license (DEA) with an expiration date of January 31, 2006. Current licenses had not been provided by the physicians. A letter was sent to Physician #1 from the administrator on December 8, 2005 indicating that his/her privileges at the facility would be suspended (no date indicated) unless a current license was provided. The physician was not suspended and the license was not provided until March 29, 2006. A letter was sent to Physician #2 from the administrator on March 16, 2006 indicating that his/her privileges at the facility would be	F 492	F492 1. All residents that where under the physician in questions care were check and no residents were found to be affected. 2. All residents were checked and no residents were found to be affected. The facility followed Its policy of checking to see if the physician maintained current credentials at other institutions. Both of the physician's credentials were current. The physicians did bring in their credentials. 3. The responsibility for monitoring physician credentials will be shifted to the Administrator's Office. The Administrator will provide a monthly status report to the Medical Director. 4. The Administrator will report the status of the physician's credentialing at the bi-annual medical staff meeting and the quarterly CQI meeting. Any physician that is out of compliance will be suspended. Physicians that are continuously out of compliance will have their privileges revoked from the facility. 5. May 5, 2006	3/30/06 3/30/06 5/5/06 Ongoing 5/5/06 Quarterly On-going 5/5/06

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F 492	Continued From page 12 suspended unless a current license was received by the facility within the next two weeks (March 30, 2006). A license was provided on March 29, 2006. According to the current licenses provided on March 29, 2006, Physician #1's District of Columbia Controlled license expired September 30, 2006 and Physician #2's DEA license expired January 31, 2009. Both physicians continued to see residents and write orders during this period. According to the facility's policy, "Attending Physicians/Consultant Staff " policy #99-001, issued from the Medical Staff Department, under, "Qualifications: All attending physicians must register with the facility, submit copies of their current and valid District of Columbia license, Federal and local Drug Enforcement Administration (DEA) registration .. " Both physicians had continuous active licenses. However, both failed to maintain a current copy of their license at the facility. The licenses were reviewed on March 29, 2006.	F 492		