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 _____	R 01/12/2010

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 000}	INITIAL COMMENTS A follow-up survey to the recertification survey completed November 9, 2009 was conducted on January 12, 2010. The following deficiencies were based on observations, record review and facility staff interviews. The sample size was 15 residents.	{F 000}	Residents #2, 3, 8 1. Residents #2, 3, 8 were assessed and records reviewed by the Medical Director on 1/26/10. There were no negative outcomes noted on these residents.	
{F 387} SS=B	483.40(c) (1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 15 sampled residents, it was determined that the physician failed to perform timely visit to Residents # 2, 3, and 8. The findings include: The physician failed to perform timely 60 day's visits for Residents #2, 3 and 8. 1. A review of Resident #2's clinical record revealed that he/she was last seen by the physician on October 10, 2009 as evidenced by the signed and dated progress note of October 10, 2009. Further review of the resident's clinical record	{F 387}	2. All other records were reviewed for timeliness of physician visits and records were updated where appropriate. 3. A follow-up memo from the Medical Director and Administrator stressing the need for compliance on timeliness of visits was sent to all attending physicians on 1/26/10. 4. Physician visits will continue to be monitored by Medical Records monthly and reported to CQI quarterly. 5. Completion date 1/26/10.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 1/26/10

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 387}	Continued From page 1 revealed that the physician reviewed, signed and dated the resident ' s December 2009 ' s " Physician ' s Order " on December 21, 2009. The resident's clinical record lacked documented evidence that the physician visited the resident after October 10, 2009. A face-to-face interview was conducted with Employee #3 on January 12, 2010 at 4:30 PM. After reviewing the resident's clinical record, he/she acknowledged that the resident ' s clinical record lacked documented evidence, that the physician visited the resident after October 10, 2009. The record was reviewed January 12, 2010. 2. A review of Resident #3's clinical record revealed that he/she was last seen by the physician on October 25, 2009 as evidenced by the signed and dated progress note of October 25, 2009. Further review of the resident ' s clinical record revealed that the physician reviewed, signed and dated the resident ' s September 2009 ' s " Physician ' s Order " on October 25, 2009 and completed a physical examination of the resident on October 25, 2009 as evidenced by a signed and dated history and physical examination form. The resident's clinical record lacked documented evidence that the physician wrote a progress note after October 25, 2009. A face-to-face interview was conducted with Employee #3 on January 12, 2010 at 4:30 PM. After reviewing the resident's clinical record,	{F 387}		

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{F 387}	Continued From page 2 he/she acknowledged that the resident's clinical record lacked documented evidence, that the physician visited the resident after October 10, 2009. The record was reviewed January 12, 2010. 3. A review of Resident #8's clinical record revealed that the physician' s last progress note was signed and dated October 24, 2009. Further review of the resident ' s clinical record revealed that the physician reviewed, signed and dated the resident ' s January 2010 ' s " Physician ' s Order " on January 9, 2010. The resident's clinical record lacked evidence that the physician wrote a progress note after October 24, 2009. A face-to-face interview was conducted with Employees # 4 and 5 on January 12, 2010 at 4:00 PM. After reviewing the resident's clinical record, they both acknowledged that the resident's clinical record lacked evidence of a physician's progress note after October 25, 2009. The record was reviewed January 12, 2010.	{F 387}		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 095020	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/12/2010

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
{F 278}	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, for one (1) of 15 sampled residents, it was determined that facility staff failed to accurately code the resident for physical functioning. Resident #2.

The findings include:

Facility staff failed to accurately code Resident #2's physical functioning.

The resident was admitted to the facility on December 31, 2008.

According to an annual Minimum Data Set (MDS) assessment completed December 30, 2009 the resident was coded in Section G (Physical Functioning and Structural Problems) as requiring extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. For "Walk in room/ walk in corridor "the resident was coded" 8/8"
meaning that the activity did not occur.

The resident was observed on January 12, 2010 at approximately 2:00 PM and 3:00 PM in the day room across from the nurse ' s station and in his/her room. The resident was observed wheeling himself/herself around his/her room and the unit.

A face-to-face interview was conducted on January 12, 2010 at 3:15 PM with Resident # 2. The resident said that though he/she uses the wheel chair, wheeling self in the room and around the unit, that he/she walks short

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
{F 278}	Continued From Page 1 distances with the help of the wheel chair. He/she further stated that he/she independently: moves in and out of the bed, dresses self, uses the toilet, and provides personal hygiene and bathing. Furthermore, the resident stated that he/she uses the toilet independently at night without staff assistance. A face to-face interview was conducted on January 13, 2010 at approximately 3:30PM with Employees # 3 and 8. Employee # 8 acknowledged the above statements by the resident in the presence of Employee # 3. The record was reviewed January 12, 2010.