STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09E020	A. BUILDING _____ B. WING _____	01/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	4200 HAREWOOD ROAD NE WASHINGTON, DC 20017

(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 January 22 through 25, 2008. The following deficiencies were based on record review, observations and interviews with facility staff. The sample included 10 residents based on a census of 39 residents on the first day of survey.	F 000		
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 10 sampled residents, it was determined that the facility staff failed to initiate a care plan for anticoagulant therapy. Resident #9 The findings include:	F 279	**F 279 483.20(d),483.20 (k)(1) Comprehensive Care Plans** 1. Care plans with appropriate approaches and goals for anticoagulant therapy were implemented and placed for review by staff on 1/23/08 for Resident #9. 2. All Residents' POFs were reviewed for use of anticoagulant therapy and care plans initiated or updated with appropriate goals and approaches. 3. The QI nurse and the MDS coordinator will continue to review care plans and educate nurses on initiating and updating care plans for Residents with new orders. This was discussed at the nurses' meeting on 2/13/08. 4. Monthly audits will be done when MARS are updated and with monthly nursing summaries. Discrepancies will be reported to the QI nurse and the MDS coordinator for review. Findings will be referred to the QI and QA committee meetings. 5. Corrective actions completed by	2/14/08.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dr Cecile Zeringue | adm | 2/18/08

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 279	Continued From page 1 A review of Resident #9's record revealed an order for "Aspirin Chew Baby 81 mg tab 1 tab PO (by mouth) every day for DVT [deep vein thrombosis] prophylaxis " written on March 7, 2007 and signed by the physician on January 9, 2008; and an order for " Coumadin 4 mg by mouth at bedtime for DVT " written on September 13, 2007 and signed by the physician on January 9, 2008. A review of the care plan dated November 29, 2007 revealed that facility staff failed to initiate a care plan with goals and approaches for anticoagulant (Aspirin, Coumadin) therapy. A face-to-face interview was conducted with Employee #1 on January 23, 2008 at approximately 11:00 AM. He/she acknowledged that the anticoagulant care plan was not present in the record. The record was reviewed on January 23, 2008.	F 279		
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, record review and staff interview for one (1) of two (2) residents who self medicate, it was determined that the facility staff failed to remove five (5) containers of expired medications from the eleven (11) medications containers found in the storage area. Resident JH1.	F 309	**F 309 483.25 Quality of Care** 1.The nurse explained to the Resident again why she needed to turn in to the nurse her expired meds and removed the 5 medications from the Residents' drawer. They were discarded per facility policy on 1/23/08. 2. All medications for Residents who self-medicate were reviewed by the nurse with the Residents on 1/23/08 as well as our policy on discarding medications that are expired or have been discontinued. 3. The DON and the QI nurse will review and educate the nurses at the next medication in-service and nurses' meeting (2/13/08) on the policy for Residents who self-medicate so that all steps are followed. 4. Monthly audits will continue to be done and completed when MARS are updated and with the Residents' monthly summaries as well as at the Residents' Care Plan Meeting. Discrepancies will be reported to the QI	

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F 309	Continued From page 2 The findings include: 22 DCMR, 3227.12 stipulates, "Each expired medication shall be removed from usage." On January 22, 2008, at approximately 12:00 PM, during an inspection of the medication storage area for Resident JH1 , five (5) containers of expired medications were observed in the drawer. The resident stated, " the medications are to be thrown away." The following medications were expired: Loratadine 10 mg tablet; expiration date 1/26/07 Benzonate 100 mg capsule; expiration date 2/6/07 Arthrotec 50 mg tablet; expiration date 11/10/07 Potassium Chloride 10 mEq tablet; expiration date 9/29/07 Acetaminophen 325 mg tablet; expiration date 2/8/07 A face-to-face interview was conducted on January 22, 2008 at approximately 12:15 PM with Employee #4. He/she stated, "Medications are checked monthly by the nurse on the unit. "	F 309	nurse and the MDS coordinator for review. Findings will be referred to the QI and QA committee meetings. 5. Corrective actions completed by	2/14/08.
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION 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.	F 323		

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

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: one (1) extension cord found in the hallway, one (1) unsecured plastic runner, one (1) unsecured rug, one (1) iron, one (1) hair dryer and one (1) shelf with unsecured boxes were found in residents' rooms. These findings were observed in the presence of Employees #3 during the environmental tour on January 22, 2008 between 8:50 AM and 10:15 AM. The findings were acknowledged by the aforementioned employee at the time of the observations. The findings include: 1. An extension cord was observed plugged into a lamp in the hallway. 2. A five (5) tier metal shelf on wheels was observed in the resident's room with unsecured boxes on each self in room 1406. 3. A clear plastic runner was observed at the bedside in room 1411. 4. An unsecured area rug was observed at the bedside, one (1) iron (unplugged) was observed on the floor, and one (1) hair dryer was observed on the floor plugged into the wall in room 1413.	F 323	**483.25(h)Accidents and Supervision** 1. The extension cord was removed on 1/22/08. The five tier metal shelf on wheels was removed from the Resident's room 1406 and returned to her storage area on 1/22/08. The clear plastic runner was removed from the bedside in room 1411 on 1/22/08. The rug in room 1413 was also removed. The iron and hair dryer were removed despite Resident's protest and placed in the clean utility room so that CNAs could get it for Resident if she needed them and supervise her use of them to assure her safety. Safety issues were explained to Res. 2. All hallways and Residents rooms were checked for potential accident hazards or for equipment that would require supervision and/or assistance to assure Residents' safety. 3. Nurses were reminded that adequate supervision and assistance is needed with devices that could be potentially dangerous to the Resident or others at the nurses' meeting on 2/13/08. An inservice on safety will be done by ~~3/15/08~~. Safety will also be discussed at the next Resident council meeting. 4. The safety inspections will continue to be done on a monthly basis and safety issues will be addressed as they occur. Nursing staff will monitor areas to assure that they are safe and free of accident hazards and audit reports will be reviewed at the safety	3/1?/08 3/08/08 per [illegible] e-mail
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.	F 371	and Resident care plan meetings as well. Discrepancies will be reported to the QI nurse and MDS coordinator for review. Findings will be referred to the QI and QA committee meetings. 5. All corrective actions will be completed	3/08/08 ~~3/10/08~~ 3/~~19~~/08.

per [illegible] e-mail

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations during the tour of dietary services, it was determined that facility staff failed to maintain an undamaged floor in the main kitchen. This observation was made in the presence of Employee #2 on January 22, 2008 from 8:15 AM to 9:30 AM. The findings include: The floor near the walk-in refrigerator was observed with an accumulation of dirt and debris between the floor and the cove base. An 8" x 6 " area of the floor near the mixer was observed to be covered with a black substance replacing a floor tile. The edges of the black substance appeared to be uneven. Employee # 2 acknowledged these findings at the time of the observations.	F 371	F371 483.35(i)(2) 1. The floor near the walk-in refrigerator was repaired 2/14/08 by putting tile floor to replace the grouting between the flooring and the cove base. Also the 8" X 6" area of the floor near the mixer covered with black grout was replaced with floor tiles on 2/14/08. 2. All the kitchen floors were checked for uneven black areas so as to assure a safe and accident free work area. 3. Staff were instructed on 2/14/08 to keep the floor free of debris. 4. Weekly inspections will be conducted by the Kitchen Manager. Findings will be referred to QA & QI committee meetings 5. Corrective actions taken	02/14/08.