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 _____	03/12/2009

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 on March 11 through 12, 2009. The following deficiencies were based on record review and staff interview. The sample size was 10, based on a census of 39 residents on the first day of survey.	F 000		
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: two (2) of three (3) soiled roller carts in the beauty shop. The environmental tour was conducted on March 11, 2009 at 12:30 PM in the presence of two (2) Beauty Shop staff. The findings were acknowledged at the time of the observations. The findings include: Two (2) of three (3) hair roller carts were observed soiled with hair and a brown substance in the beauty shop.	F 253	1. The curlers were disinfected as per procedure and the curler carts cleaned on March 11th immediately following the inspection tour. 2. The curler carts will be checked on a weekly basis and cleanliness and sanitary measures ensured after each beautician visit. 3. The responsible staff person was in-serviced by her supervisor on the proper procedures on March 13th. A log will be maintained with the date that the carts were checked and cleaned. 4. A member of the Quality Assurance Committee will review the logs on a weekly basis and will do random checks to assure that the carts are kept clean and orderly and curlers have been disinfected.	3/18/09
F 329 SS=D	483.25(l) 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	F 329	1. Resident #1's medications were reviewed by the physician on 3/24/09 and documentation on the ordered Seroquel provided. State and Federal Regulations and facility policy regarding	4/17/09

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

Sr. Alphonse Marie Jones | Administrator | 4/2/2009

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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	09E020	A. BUILDING _____ B. WING _____	03/12/2009

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F 329	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for three (3) of 10 sampled residents, it was determined that the physician failed to attempt a gradual dose reduction for antipsychotic medications for Residents #1, 2, and 6. The findings include: According to the facility's policy, "Psychoactive Drugs" page 1 of 2 "A resident receiving these drugs [Antipsychotic Drugs] unless clinically contraindicated receives gradual dose reductions, or behavior interventions in an effort to discontinue these drugs."	F 329	Antipsychotic usage and unnecessary drugs were reviewed with the physician. Resident #2's medications were reviewed by the physician on 3/31/09 and documentation on the ordered Risperdal provided. State and Federal regulations and facility policy regarding antipsychotic usage and unnecessary drugs were reviewed with the physician. Resident #6's medications were reviewed by the physician on 3/17/09 and documentation on the ordered Zoloft provided. State and Federal regulations and facility policies regarding antipsychotics usage and unnecessary drugs were reviewed with the physician. 2. All of the Residents' charts were audited for antipsychotic usage, physician review and timely documentation. Monitoring sheets were completed for review by the DON and ADON so that appropriate follow-up could be initiated if indicated. 3. The QI nurse or designee will continue to monitor the usage of psychotropic medications in order to ensure timely review, appropriate action and documentation by the attending physician or psychiatrist through monthly audits. 4. A quarterly report based on the monthly nurse audits will be submitted to the Quality Improvement/Quality Assurance Committee. Any necessary follow-up will be initiated by the consultant pharmacist or the DON/ ADON.	

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F 329	Continued From page 2 1. The physician failed to attempt a gradual dose reduction or document if clinically contraindicated for Seroquel for Resident #1. A review of Resident #1's record revealed a physician's order initiated March 23, 2008 which directed, "Seroquel 25 mg tab Give 1 tab by mouth twice every day for Anxiety and Agitation." The above order was renewed May 16, 2008, July 15, 2008, September 17, 2008, November 15, 2008, January 16, 2009 and March 10, 2009. A review of the Medication Administration Record (MAR) for March 2008 through March 2009 revealed that the resident received Seroquel 25 mg by mouth twice daily while in the facility. A review of the Behavioral Management Flow Sheet revealed that Resident was agitated 29 times from March 2008 through March 2009. There was no evidence in the record that the physician or psychiatrist attempted a dose reduction of Seroquel or documented if clinically contraindicated. A face-to-face interview was conducted with Employees #4 at approximately 10:00 AM on March 11, 2009. He/She acknowledged that there was no attempted dose reduction for Seroquel on the record. The record was reviewed on March 11, 2008. 2. The physician failed to attempt a gradual dose reduction of Risperdal for Resident #2. A review of Resident #2's record revealed a physician's order dated July 15, 2008	F 329		

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F 329	Continued From page 3 "Risperidone Tab 0.5 mg for Risperdal, Take 1 tablet by mouth at bedtime for anxiety." A review of the Medication Administration Record (MAR) for March 2008 through March 2009 revealed that the resident received Risperdal 0.5 mg at bedtime daily while in the facility. Physician's progress notes were in the record and dated July 8, 2008, September 7, 2008, October 28, 2008, and December 23, 2008 and February 17, 2009. The progress notes lacked documentation that the use of the Risperdal was addressed. Further review of the physician's progress notes also failed to reveal documentation of any attempt at dose reduction of the Risperdal. A face-to-face interview was conducted with Employee # 4 on February 12, 2009 at approximately 11:40 AM. He/she acknowledged that the record lacked documented evidence of any attempt to reduce the dose of the Risperdal. The record was reviewed on March 11, 2009. 3. The physician failed to attempt a gradual dose reduction or document if clinically contraindicated for Zoloft (Sertraline) for Resident #6. A review of Resident #6's record revealed a physician's order initiated February 5, 2008 which directed, "Zoloft 100 mg po qd [By mouth daily]." A review of the resident's "Physician Order Forms" revealed that the above cited order was renewed on March 4, April 29, June 24, August 9, October 14, and December 9, 2008, and February 3, 2009.	F 329		

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F 329	Continued From page 4 According to the MAR for March through December 2008 and January through March 11, 2009, the resident received Zoloft 100 mg daily at 7:00 PM while in the facility as evidenced by the nurses' initials in the designated area documenting that the medication had been administered. A review of Resident #6's record revealed that physician progress notes were in the record dated August 9, October 14, and December 9, 2008, and January 3, 2009. A further review of the resident's clinical record revealed that the resident was seen by the psychiatrist on March 31, 2008 as evidenced by the psychiatrist's notes. There was no evidence in the resident's clinical record that the physician or psychiatrist attempted a dose reduction of Zoloft after March 31, 2009. After reviewing Resident #6's clinical record on March 12, 2009, at approximately 10:30 AM, Employee #4 acknowledged that the resident's clinical record lacked evidence that the physician and or the psychiatrist attempted gradual dose reduction for Zoloft or documented if clinically contraindicated. The record was reviewed March 12, 2009.	F 329		
F 371 SS=D	483.35(i) SANITARY CONDITIONS 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	F 371	1. The spotted tomatoes and the undated dried berries were disposed of immediately in the presence of the surveyor during the inspection. The plate of assorted lunch meats and cheese were labeled and dated during the inspection. The packages of improperly stored turkey were disposed of immediately in the presence of the	3/30/09

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F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served in a safe and sanitary manner as evidenced by: foods observed undated in two (2) of four (4) walk-in refrigerators: 16 of one (1) case of undated tomatoes with green, white and black spots on the tomatoes, one (1) of two (2) trays of lunch meat and one (1) of two (2) containers of dried berries, and one (1) of one (1) dry storage area; and damaged ceiling in one (1) of one (1) holding area. The tour of the main kitchen was conducted on March 11, 2009 from 9:15 AM until 10:20 AM. These findings were acknowledged by Employee #1 at the time of the observations. The findings include: 1. The following foods were observed undated in the walk-in refrigerator and the dry storage area: A. 16 of one (1) case of tomatoes observed with green, white and black spotted areas on the tomatoes. B. One (1) of two (2) trays of assorted lunch meat and cheese undated. C. One (1) of two (2) containers of dried berries undated in the dry storage area 2. The following was observed improperly stored	F 371	surveyor during the inspection. The cracked outer layer of the sheet rock ceiling in the holding area was peeled away and the area skimmed, refinished and sealed with a 100% acrylic coating and mold and mildew-resistant kitchen gloss. Ceiling repair was completed on March 30, 2009. 2. All produce will be inspected daily by designated dietary staff. Any item(s) found to be of inferior quality or improperly stored will continue to be discarded. 3. An inservice education session was conducted by the food service manager for kitchen staff on March 13th reviewing methods which ensure the maintenance of sanitary conditions: proper storage, labeling, preparation, distribution and serving of food. 4. The food service manager will monitor on a weekly basis through visual inspection the correct storage, labeling and dating of all foods. Any findings will be corrected and reported to the Quality Improvement/Quality Assurance committee with appropriate follow-up in the dietary department and further inservice as indicated.	

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F 371	Continued From page 6 in the walk-in refrigerator: Six (6) of six (6) packages of mechanically separated turkey was observed stored in walk-in refrigerator. The manufactures label [on the package] directed, " Keep Frozen " .	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 10 sampled residents, it was determined that the physician failed to review the total plan of care for Residents #1, 2 and 6. The findings include: 1. The physician failed to review the use of Seroquel in the total plan of care for Resident #1. A review of Resident #1's record revealed a physician's order initiated March 23, 2008 directing, "Seroquel 25 mg twice daily for Anxiety and Agitation." The above cited order was renewed May 16, July 15, September 17, November 15, 2008, January 16, 2009 and March 10, 2009	F 386	1. The total plans of care for Residents' #1, 2, and 6 were reviewed by the physician to ensure that either dosage reduction was ordered or documentation was provided to explain why a dosage reduction was clinically contraindicated at this time or in the past. Behavioral interventions are in place and were also reviewed by the attending physician. 2. All Residents' on psychotropic medications had their POFs reviewed by the ADON to ensure that dosage reduction was done or appropriate documentation provided by the physicians. All care plans were reviewed as well as chart audits done to assure that behavioral interventions were also in place and nursing documentation was complete. The appropriate physician will be notified in writing to request either gradual dosage reduction or documentation in order to explain why it is clinically contraindicated, if one or the other of those is missing or incomplete. 3. All recommendations by the pharmacy consultant regarding psychotropic medications will be reviewed by the attending physicians and appropriate response made.	4/17/09

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F 386	Continued From page 7 A review of Resident #1's record revealed that the physician visited the resident on April 2, June 17, August 1, September 24, and November 19, 2008, and January 4, 2009 and March 10, 2009. There was no evidence in the physician ' s progress notes that the use of Seroquel was addressed. A face-to-face interview was conducted with Employees #4 on March 11, 2009 at 10:15 AM who acknowledged that the physician failed to address the use of Seroquel in his/her progress notes. The record was reviewed March 11, 2009. 2. The physician failed to address use of Risperdal in the total plan of care for Resident # 2. A review of Resident #2 ' s record revealed a physician ' s order dated July 15, 2008, " Risperidone Tab 0.5mg for Risperdal, Take 1 tablet by mouth at bedtime for anxiety. " The medication was last reordered on February 17, 2009. A diagnosis of Anxiety was also documented on the Physician's Order Form (POF). Further review of the POF revealed that no dose reduction was attempted between July 15, 2008 and March 12, 2009. A review of the physician ' s progress notes revealed notes dated July 8, 2008, September 7, 2008, October 28, 2008, and December 23, 2008 and February 17, 2009. The progress notes lacked documentation that the use of the Risperdal addressed. A face-to-face interview was conducted with	F 386	As part of the review of the total plan of care for each Resident the attending physicians will continue to review their care plan and documentation of behavioral symptoms. A list of residents on any psychotropic medications (antipsychotics, anxiolytics, antidepressants, etc.), provided by the pharmacy on a monthly basis, will be utilized by the physicians in their review of the Residents' total plan of care. The results and recommendations of this survey were discussed with the medical director and physicians who come to the Home. 4. The list of Residents on any psychotropic medications (antipsychotics, anxiolytics, antidepressants, etc.) will form the basis of monitoring by the attending physicians, the QI nurse, and the medical director as to whether dosage reduction or documentation has been done on a timely basis since initiation of the medication by the physician. Any findings will be evaluated and a summary presented at the quarterly Quality Assurance meeting. Appropriate follow-up by the Medical Director will be done in order to assure any necessary correction and compliance.	

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Employee #4 on February 12, 2009 at approximately 11:40 AM. He/she acknowledged that the record lacked documented evidence that the physician addressed the use of Risperdal. The record was reviewed on March 11, 2009.

3. The physician failed to address use of Zoloft in the total plan of care for Resident # 6.

A review of Resident #6's record revealed a physician's order initiated February 5, 2008 directing, "Zoloft 100mg po. qd [By mouth daily]."

The above cited order was renewed March 4, 2008, April 29, 2008, June 24, August 9, 2008, October 14, December 9, 2008 18, and February 3, 2009.

A review of the resident ' s record revealed that the resident was seen by the psychiatrist on March 31, 2008.

A further review of Resident #6's record revealed that the physician visited the resident on August 9, October 14, and December 9, 2008, and January 3, 2009.

There was no evidence in the resident ' s clinical record that the physician addressed the resident's use of Zoloft for depression after the psychiatrist ' s March 31, 2008 ' s visit.

After reviewing Resident #6's clinical record on March 12, 2009, at approximately 10:30 AM, Employee #4 acknowledged that the physician ' s progress notes lacked evidence that he/she addressed the resident's use of Zoloft for depression after the resident was seen by the psychiatrist on March 31, 2008. The record was

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F 386	Continued From page 9 reviewed March12, 2009.	F 386		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW 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 interviews for three (3) of 10 sampled residents, it was determined that the pharmacist failed to report to the Physician and Director of Nursing that dose reduction for the use of antipsychotic medications had not been attempted for Residents #1, 2, and 6. The findings include: 1. The Pharmacist failed to report to the physician and Director of Nursing that an attempted dose reduction for Resident #1, who was receiving Seroquel, had not been attempted. A review of Resident #1's record revealed a physician's order initiated March 23, 2008, directing, "Seroquel 25 mg twice daily for Anxiety and Agitation." The above cited order was renewed May 16, July 15, September 17, November 15, 2008, January	F 428	1. The charts of Residents' #1, 2, and 6 were reviewed by the pharmacist on March 25th to ensure that either dosage reduction was ordered or documentation was provided for not attempting it by the attending physician or psychiatrist. Appropriate documentation has been completed by the attending physicians of the above-listed Residents as of the date of the pharmacist's review. 2. To prevent future occurrences, all Residents' drug regimens will be monitored on a monthly basis. The records of residents on psychotropic medications will be audited to ensure that dosage reduction is attempted and/or appropriate documentation provided. If neither one is provided on a timely basis, written notification to the physician will be generated by the pharmacist to request this action. 3. All recommendations by the consulting pharmacist regarding psychotropic medications and/or other medications will continue to be forwarded to and reviewed by the attending physicians and appropriate action taken. Monthly follow-up on the recommendations will be done by the consultant pharmacist in order to ensure ongoing compliance.	3/25/09

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F 428	Continued From page 10 16, 2009 and March 10, 2009. A review of the Medication Administration Record (MAR) for March 2008 through March 2009 revealed that the resident received Seroquel 25 mg by mouth twice daily while in the facility. A review of the Behavioral Management Flow Sheet revealed that Resident #1 was agitated 29 times from March 2008 through March 2009. According to the "Chronological Record of Drug Regimen Review," the pharmacist conducted a review of the resident's medication on, April 14, May 15, June 12, July 15, August 14, September 15, October 10, 2008, November 12, and December 12, 2008 and January 12, and February 16, 2009. There was no evidence that the pharmacist reported to the physician and Director of Nursing that a gradual dose reduction for Seroquel was not attempted since the medication was ordered on March 23, 2008. A face-to-face interview was conducted with Employee #4 on March 11, 2009 at 10:30 AM. He/she acknowledged that there were no irregularities reported by the pharmacist regarding the use of Resident #1's Seroquel. The record was reviewed March 11, 2009. 2. The Pharmacist failed to report the physician and Director of Nursing that an attempted dose reduction for Resident #2, who was receiving Risperdal, had not been attempted. A review of the Physician ' s Order Sheets (POS) in the resident ' s clinical record revealed that the	F 428	4. A list of Residents receiving any psychotropic medications (antipsychotics, anxiolytics, antidepressants, etc.) is provided monthly by the pharmacy. This list will form the basis of quarterly monitoring by the consultant pharmacist as to whether dosage reduction or appropriate documentation by the attending physician or psychiatrist has been done in a timely manner since initiation of the medication. These reports will be reviewed by the Quality Improvement/Quality Assurance Committees to ensure compliance and to take further action if indicated.	

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resident was started on Risperdal on July 15, 2008. The order directed the following: " Risperidone Tab 0.5mg for Risperdal, Take 1 tablet by mouth at bedtime for anxiety. The medication was last reordered on February 17, 2009.

A review of the Medication Administration Record (MAR) for March 2008 through March 2009 revealed that the resident received Risperdal 0.5 mg at bedtime daily while in the facility.

A review of the Pharmacist ' s Review Sheets revealed that the pharmacist reviewed the resident ' s clinical record on July 15, 2008, August 14, 2008, September 15, 2008, October 10, 2008, November 12, 2008, and December 12, 2008, and January 12, 2009 and February 16, 2009. There was no evidence that the pharmacist recommended attempting a dose reduction of Risperdal for any of those months.

A face-to-face interview was conducted with Employee #4 on March 12, 2009 at approximately 11:40 AM. He/she acknowledged that the record lacked documented evidence of any attempt to reduce the dose of the Risperdal. The record was reviewed on
March 11, 2009.

3. The Pharmacist failed to report the physician and Director of Nursing that an attempted dose reduction for Resident #6, who was receiving Zoloft, had not been attempted.

A review of Resident #6's record revealed a physician ' s order initiated February 5, 2008 that directed "Zoloft 100 mg po qd [by mouth daily]." The order was renewed March 4, 2008, April 29,

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 _____	03/12/2009

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 428	Continued From page 12 2008, June 24, August 9, 2008, October 14, December 9, 2008 18, and February 3, 2009. According to the MAR for March through December 2008 and January through March 11, 2009, the resident received Zoloft 100 mg daily at 7:00 PM while in the facility as evidenced by the nurses ' initials in the designated area documenting that the medication had been administered. A review of Resident #6's record revealed that the physician visited the resident on August 9, October 14, and December 9, 2008, and January 3, 2009 as evidenced by the physician ' s progress notes in the resident ' s clinical record. The pharmacist documented on the "Chronological Record of Medication Regimen Review" that a monthly review of medications was conducted on May 15, June 12, July 15, August 14, September 15, October 10, November 12, and December 12, 2008 and January 12, February 16, and March 11, 2009. The pharmacist indicated that there was "No Recommendation Made" regarding the resident's medications for each review. A face-to-face interview was conducted with Employee #4 on March 11, 2009 at 10:30 AM. He/she acknowledged that there were no irregularities reported by the pharmacist regarding the use of Resident #1's Seroquel. The record was reviewed March 11, 2009.	F 428		