STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J B JOHNSON NURSING CENTER	901 FIRST STREET NW WASHINGTON, DC 20001

(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 March 4 through 7, 2008. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 29 residents based on a census of 191 residents on the first day of the survey and six (6) supplemental residents.	F 000	**JB Johnson Nursing Center makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This plan of Correction (POC) is prepared and /or executed solely because it is required by Federal and State Law.**	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	1. Resident #5 was re-assessed and no further stools were noted to be "black" in color. Additionally, blood levels and vital signs have been normal and resident is stable. Facility cannot retrospectively correct responsible party notification regarding resident #5's positive stool and colonoscopy follow up. Facility notified responsible party and attending physician of resident #8's and #11's refusal of care and verbal abuse, and documented notification in clinical record. 2. A review of the clinical record for positive stool cultures and /or colonoscopy was done. No other residents were found to be affected by this practice. A review of all residents with care refusals and verbally abusive behavior was completed to ensure family and physicians are notified. The licensed nurses will be re-educated on proper documentation of notification. 3. A log has been created to track colonoscopy appointment; follow-up appointments and family notification. Nursing personnel will be re-educated on the new appointment log. Care refusals and verbally abusive behavior will be reported on the 24 hour report until both family and physician are notified. The licensed nurse will be re-educated on proper documentation of notification. 4. Monthly audits of appointment logs will be reported at Quality Improvement meeting. Documentation on 24 hour reports when there are care refusals and verbally abusive behavior is exhibited will be incorporated in the Quality Improvement monthly audit tool.	4/25/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Grace Eluma RNC | TITLE: Acting Administrator | (X6) DATE: 03/31/08

A 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 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 29 sampled residents, it was determined that facility staff failed to notify the responsible party of a positive stool guaiac and scheduled colonoscopy procedure for one (1) resident and verbally abusive behavior and refusal of care for two (2) residents. Residents #5, 8 and 11. The findings include: 1. Facility staff failed to notify the responsible party of Resident # 5's positive stool guaiac and scheduled colonoscopy. A review of the resident's record revealed the following nursing notes: October 30, 2007 at 7:00 AM, "At 6:30AM, Writer was called by CNA [Certified Nursing Assistant] to take a look at Resident's stool. It was very black in color. Writer tested it for occult blood and it was positive...Resident appeared weak but stable..." December 12, 2007 at 3:00 PM, "...Colonoscopy scheduled for January 15, 2008 at 8:00 AM ..." January 14, 2008, Colonoscopy [preparation] not done because consent form was not signed by responsible party. Will reschedule appointment and [follow-up with responsible party] ..." A doctor's telephone order of October 30, 2007 directed, "G.I. consult for positive stool guaiac."	F 157		

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F 157	Continued From page 2 A G.I. [Gastrointestinal] consultation report signed by the physician and dated December 12, 2007 and January 16, 2008 directed "Colonoscopy...see instruction and consent form ..." A face-to-face interview was conducted with Employee # 8 on March 7, 2008 at approximately 11:00 AM. He/she acknowledged that the resident's record lacked evidence that the resident's responsible party was informed that the resident had a positive guaiac stool and of the GI consultant's recommendation for colonoscopy. The record was reviewed on March 7, 2008. 2. Facility staff failed to notify the physician and responsible party of Resident #8's verbally abusive behavior and care refusal. A review of Resident #8's record revealed a significant change Minimum Data Set (MDS) completed October 26, 2007 with the following diagnosis: Diabetes Mellitus, Arthritis, Parkinson's Disease, Seizure Disorder, Schizophrenia, and Dementia other than Alzheimer's. A Review of the nurses' notes revealed the following: December 30, 2007 at 9:00 AM: " ...Refused VS (vital signs) ..." December 31, 2007 at 10:30 PM: " ...pulse is regular and strong, vitals refused, verbally towards CNA [certified Nursing Assistant] ..." January 13, 2008 at 9:00 PM: " ...S/P Fx. R arm [status post right] Refused V.S ..." January 14, 2008: at 10: 30 PM " ...V/S refused	F 157		

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F 157	Continued From page 3 ..." January 16, 2008 at 6:00 AM: "Routine incontinent care/ meds given, VS [vital signs refused on two attempts]. March 3, 2008 at 3:00 PM: " ...ABT in progress ...V/S refused" March 3, 2008 at 10:00 PM: "Resident is alert and oriented up and about propelling wheel chair around on and off the unit verbally abusive towards staff and other residents. Medicated with Haldol 2mg IM [intramuscular] for agitation ...refused temperature ..." January 1, 2008 at 7: 00 AM "Resident refused AM F/S [fingerstick] ..." The aforementioned incidents lacked evidence that the physician and responsible party was notified that the resident was verbally abusive and refusing care. A face-to-face interview was conducted with Employee #24 on March 6, 2008 at approximately 2:15 PM. He she acknowledged that the record lacked evidence that the physician was notified of Resident # 8's care refusals and verbal abuse behavior. The record was reviewed on March 6, 2008. 3. Facility staff failed to notify the physician and responsible party of Resident #11's verbally abusive behavior and care refusals. A review of Resident #11's record revealed a significant change Minimum Data Set (MDS) completed November 12, 2007 with the following	F 157		

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F 157	Continued From page 4 diagnosis: Diabetes Mellitus, Deep Vein Thrombosis, Hypertension, Dementia Senile (290.0), HIV Disease (042), and Dementia other than Alzheimer's. A review of the nurse's notes revealed the following: October 27, 2007 at 8:10 PM, " This writer took meds [medications] to resident in his/her room] resident refused to take any of the PM [evening] meds. Writer wasted the meds." October 5, 2007 at 9:00 PM, "This writer took meds to resident at 9:00 PM. Resident stated 'I am watching my movie ..." October 5, 2007 at 10:00 PM, "Writer took meds to resident again the second time and resident stated ' ...I don't want any meds from you [because I do not trust you ..." November 10, 2007 at 3:30 PM, "Dressed and ready to leave facility at noted time, refused to have FSBS [Finger stick Blood Sugar] taken ..." December 28, 2007 a 6:30 AM, "Resident got out of bed and start yelling and fussing at Caregiver ..." December 29, 2007 at 6:30 AM, "Resident continues to yell at staff ..." January 1, 2008 at 10:00 AM, "Resident refused to have insulin this morning ..." January 5, 2008 at 3:00 PM, "The writer was sitting at the nurse's station. Resident walked up to writer and said; ' ...One day you will be in my hands and you will cry ..."	F 157		

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F 157	Continued From page 5 February 5, 2008 at 11:00 PM, " ...Resident had a verbal altercation with a staff ..." March 4, 2008 at 11:00 AM, "This resident refused to take the 9:00 AM [morning] meds. Resident also denied BP [blood pressure] and will not take water. This writer attempted three times. Meds wasted. BP not done ..." On March 5, 2008, the social worker's progress note read: "Unit Manager reported that the resident threatens the charge nurse on March 4, 2008 ..." The aforementioned incidents lacked evidence that the physician and responsible party were notified that the resident was verbally abusive and refusing care. A face-to-face interview was conducted with Employee #19 on March 6, 2008 at approximately 12:45 PM. He she acknowledged that the record lacked evidence that the physician and responsible party were notified of Resident #8's care refusals and verbally abusive behavior. The record was reviewed on March 6, 2008.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private	F 164		

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F 164	Continued From page 6 room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for one (1) of three (3) wound treatments, it was determined that facility staff failed to provide privacy for Resident H1 during a wound treatment. The findings include: A wound treatment was observed on March 7, 2008 at 11:00 AM for the right ankle. During the wound treatment, it was observed that the nurse failed to close the door to the resident's room and/or pull the privacy curtain around the resident's bed. A face-to-face interview was conducted immediately after the wound treatment with	F 164	1.Employee #11 was interviewed and verbalized that the door was approximately 90% closed and the curtain was 75% around the resident in an effort to allow surveyor to observe the dressing change. No other residents were in the room. Facility cannot retrospectively correct failure to completely close the door to resident's room and to completely pull the privacy curtain during wound care. 2. Nursing managers have observed other residents who may need wound treatment and no other resident was affected by this practice. 3. Nursing personnel was re-educated on closing the door to resident's room and pulling the privacy curtain during wound care. 4. Observations of nursing staff during wound care will be reported at Quality Improvement meeting monthly.	4/25/08

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F 164	Continued From page 7 Employee #11. He/she acknowledged that the privacy curtain should have been pulled around the resident's bed and the door should have been shut before the treatment was administered.	F 164		
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 observations and staff interview, it was determined that facility staff failed to knock on residents' doors before entering during medication pass observations and wrote on one (1) resident's wound dressing after application to the resident. Residents 3, 23, JH1, JH2 and H1. The findings include: 1. Facility staff failed to knock on four (4) residents' doors before entering during medication pass. On Tuesday, March 4, 2008, at approximately 9:15 AM, during the medication pass Employee #17 entered the rooms of Residents #3, 23 and JH1 without knocking. On Wednesday, March 5, 2008, at approximately 9:00 AM, during the medication pass Employee #16 entered the room of Resident JH2 without knocking. At the time of the observations Employees #16 and #17 acknowledged that they did not knock on	F 241	1. An interview was conducted with employee #17 while she had a 0% medication pass error rate for residents # 3, 23& JH1 she acknowledged that due to this being her first survey with a survey team she did not knock. Employee #16 also has a 0% medication pass error rate for all residents observed including JH2. Employee #11 was interviewed and verbalized that she wrote on tape prior to applying to resident H1's dressing. Facility cannot retrospectively correct staff's failure to knock on a resident's door before entering for medication pass or writing on resident's wound dressing. 2. Close observation of staff during medication pass and wound care was done and no other resident was affected by this practice. 3. Nursing staff will be re-educated on dignity including privacy and treatment protocol. 4.Observations of nursing staff during wound care and medication pass will be reported at Quality Improvement monthly meeting.	4/25/08

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F 241	Continued From page 8 the residents' doors prior to entry. 2. Facility staff wrote on the resident's wound dressing after application to Resident H1. A wound treatment was observed on March 7, 2008 at 11:00 AM of the right ankle for Resident H1. The nurse completed the wound treatment, applied 4 x 4 gauze, wrapped the dressing with kling gauze and taped the dressing. The nurse then wrote the date and his/her initials on the tape that was already applied to the wound dressing. A face-to-face interview with Employee #11 was conducted immediately after the wound treatment. Employee #11 acknowledged that he/she should have written the date and his/her initials on a separate piece of tape and then applied it to the wound treatment.	F 241		
F 253 SS=E	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 environmental tour, it was determined that facility staff failed to maintain a sanitary facility as evidenced by: soiled baseboards, bed frames, corners, Heating Ventilation and Air Conditioning (HVAC) units, lower window sills, caulking; marred/scarred/ soiled/damaged walls and ceiling tiles and rusted shower room doors. These observations were made in the presence of Employees #1, 2 and 3 on March 7, 2008 from 8:30 AM through 11:00 AM.	F 253	1. All baseboards, bed frames, corners and lower Portion of window sills identified in report will be corrected by 4/25/08. Additionally the interior surface of HVAC and caulking of shower rooms, and TV room will be completed by 4/25/08. The walls surfaces in the rooms and ceiling tiles identified in the survey will be corrected by 4/25/08. Shower room doors on 4North and 4 South have been reviewed by outside contractors and will be repaired or replaced. No residents were affected by this practice. 2. Assessment was done of resident rooms and common areas including baseboards, bed frames, corners, HVAC, window sills and caulking. Additional review of wall surfaces, doors and ceiling tiles were conducted. A schedule has been completed to correct any areas of concern identified. 3. A room log has been developed by the Environmental Services Director and Supervisor. Staff has been in-serviced on the usage and resident room and common area requirements. This will be utilized for common area inspection. During monthly and quarterly filter changes the HVAC will be cleaned with a shop vac.	

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F 253	Continued From page 9 The findings include: The following items were observed soiled: 1. Baseboards in rooms: 103, 123, 1N by the water fountain, 1S TV lounge, 1N soiled utility room and 230 in six (6) of 24 rooms/areas observed. 2. Bed frames in rooms: 103, 104, 107, 110, 114, 119, 122, 123 and 207 in nine (9) of 24 rooms observed. 3. Corners in rooms: 105, 107, 110, 114, 122, 1N in the TV room, 1N clean utility room, 214, 215, 221, 230, 4N soiled utility room and 4N dining room in 13 of 36 rooms observed. 4. HVAC units soiled on the interior of the front panel: 104, 105, 122, 203, 207, 210, 215, 219, 221, 228, 234, 406, 407, 410, 411, 415, 416, 426, and 433 in 19 of 36 HVAC units observed. 5. Lower portion of window sills in rooms: 103, 104, 105, 112, 114, 123 and 214 in seven (7) of 24 window sills observed. 6. Caulking: 1N shower room, 2S and 2N shower rooms, 3N TV room by the windows and 3N shower room in five (5) of 30 rooms observed. The following were soiled/marred/scarred/damaged: 1. Walls in rooms: 103, 105, 110, 111, 114, 216, 234, 407, 416, 426, and 4S by the TV room in 11 of 36 rooms observed.	F 253	Additionally, the Engineering Director has re-educated Engineering staff and met with Environmental Services Director to coordinate inspection and repair of shower rooms, caulking, and walls and ceiling tiles. 4. The Directors of Engineering and Environmental Services will monitor and conduct audits of rooms and common areas. This inspection will be reported in the QA meeting.	4/25/08

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F 253	Continued From page 10 2. Ceiling tiles in rooms: 112, 114, 203, 207, 211, 215, 216, 2S TV room, 2N shower room, 406, 4 N TV room, 4N janitorial closet, 4N shower room in 13 of 36 rooms observed. 3. The bottom of the 4N and 4S shower room doors were observed rusted in two (2) of two (2) shower room doors observed on the 4th floor. Employees #1, 2 and 3 acknowledged these findings at the time of the observations.	F 253		
F 278 SS=D	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	F 278	1. Resident's # 12, 17 and 21 were reassessed, Including a review of the clinical record. The MDS Coordinator did a significant correction to address #12's diabetes diagnosis, #17's fall and #21's dialysis. The Pharmacy was also called immediately to add diabetes as a diagnosis for resident # 12. 2. A review of all charts has been conducted to ensure no other residents have been affected by this practice. 3. MDS training has been scheduled with an independent MDS expert (consultant) on April 8th and 9th for MDS coding. 4. The monitoring of the MDS is a part of the monthly auditing process. This information is a part of the Quality Improvement process, and presented at the Quality Improvement meetings.	4/11/08

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F 278	Continued From page 11 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 29 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for: one (1) resident for falls, one (1) resident for Diabetes Mellitus and one (1) resident for dialysis. Residents #12, 17, and 21. The findings include: 1. The facility staff failed to code Resident #12 for Diabetes Mellitus under Section I of the Minimum Data Set (MDS). Resident #12 was admitted to the facility on August 3, 2007. A review of a physician's order written on August 23, 2007 and signed on September 6, 2007 revealed the following: " Start Glipizide XL 5mg PO (by mouth) q (every) day for Diabetes. Add Diabetic to the dx (diagnosis). " A review of three (3) quarterly Minimum Data Sets (MDS) assessments completed November 15, 2007, January 28 and March 7, 2008 lacked evidence that the resident was coded for Diabetes Mellitus in Section I (Disease Diagnoses). A face-to-face interview was conducted with Employee #7 at approximately 2:30 PM on March 6, 2008. He/she acknowledged that none of the MDS assessments was coded for Diabetes Mellitus in Section I. The record was reviewed on March 6, 2008.	F 278		

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F 278	Continued From page 12 2. Facility staff failed to code Resident #17 for falls on the quarterly MDS. A review of the quarterly MDS, completed November 6, 2007, in Section J4, " Accident " was coded for "None of the above". The nursing notes dated August 31 and September 10, 2007 documented that the resident fell from the wheelchair. A face-to-face interview was conducted with Employee #20 on March 6, 2008 at 11:00 AM. He/she acknowledged that the resident fell on August 31 and September 10, 2007. The record was reviewed March 10, 2008. 3. Facility staff failed to code Resident # 21 for dialysis on the admission, significant change and quarterly MDS. A review of Resident #21's record revealed the following physician's orders dated September 10 and October 23, 2007: "Dialysis on Tuesday-Thursday-Saturday " . According to the admission MDS completed September 21, 2007, a significant change MDS completed on November 6, 2007 and a quarterly MDS completed on February 5, 2008, the resident was not coded for dialysis in Section P, " Special Treatments, Procedures and Programs." On March 7, 2008 at approximately 11:30 AM, a face-to-face interview was conducted with Employee #7. He/she acknowledged that the resident was not coded for dialysis on the MDS assessments completed on September 21 and	F 278		

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F 278	Continued From page 13 November 6, 2007 and February 5, 2008. The record was reviewed on March 7, 2008.	F 278		
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 29 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to initiate care plans for: the management of Diabetes Mellitus for one (1) resident and for physical aggression for one (1) resident. Residents #12 and S2. The findings include:	F 279	1. The comprehensive care plan for resident #12's diagnosis of diabetes was reviewed and diabetes was addressed on the "at risk for weight loss care plan". An additional care plan has been written to address diabetes separately which includes goals and approaches. A review of resident # S2's care plan was completed and while the resident has a detailed care plan addressing verbal aggression. It was necessary to update the care plan to include physical aggression. 2. A review of all resident's charts with diabetes and physical aggression was done. No other residents were found to be affected by this practice. 3. Nursing personnel will be re-educated on updating care plans to reflect diabetes and physical aggression. 4. Care plan audit will be reported at Quality Improvement monthly meeting.	3/25/08

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F 279	Continued From page 14 1. Facility staff failed to develop a care plan for Resident #12 for the management of Diabetes Mellitus. A review of the record revealed that Resident #12 was admitted to the facility on August 3, 2007. A physician ' s order written on August 23, 2007 and signed on September 6, 2007 stated, " Start Glipizide XL 5mg PO (by mouth) q (every) day. Add Diabetic to the dx.(diagnosis)." The care plan last reviewed on February 5, 2008, lacked evidence that there was a problem identified with appropriate goals and approaches for the management of Diabetes Mellitus. A face-to-face interview was conducted with Employee #7 at approximately 2:30PM on March 6, 2008. He/she acknowledged that the care plan lacked goals and approaches for the management of Diabetes Mellitus. The record was reviewed on March 6, 2008. 2. Facility staff failed to develop a care plan for Resident S2's physical aggression. A review of Resident S2's record revealed the following nurses' notes: December 28, 2007 at 11:40 PM, "[Resident S2] blocking passage way and another male in a wheelchair attempted to pass ...[Resident S2] got up from wheelchair and hit the other resident and the other resident hit [Resident S2] back. " March 3, 2008 at 12:00 PM, "... Identified by another resident as the [man/woman] who kicked [another resident] yesterday ... "	F 279		

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F 279	Continued From page 15 The resident's care plan was reviewed by the interdisciplinary team on February 14, 2008. There was no evidence that a care plan with appropriate goals and approaches for physical aggression was initiated. A face-to-face interview was conducted with Employee #19 on March 7, 2008 at 10:00 AM. He/she acknowledged that the resident did not have a care plan for physical aggression. The record was reviewed March 7, 2008.	F 279		
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 record review and staff interview for two	F 280	1. A review of the clinical record for resident #8 and #17 was completed, while both have care plans on falls it was necessary to update both care plans. 2. A review of all charts with falls was done. No other residents were found to be affected by this practice. 3. Interdisciplinary team will be re-educated on care plan updates 4. Monthly audits of care plans will be reported at Quality Improvement monthly meeting	4/25/08

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F 280	Continued From page 16 (2) of 29 sampled residents, it was determined that facility staff failed to update the care plan for two (2) residents after falls. Residents #8 and 17. The findings include: 1. Facility failed to update Resident #8's care plan after a fall. A review of the resident ' s record revealed the following nurse ' s note: February 25, 2008 at 11:00 AM, " ...Resident stated [I was trying to get my shoe but I was unable to get it]. No injury noted ". The care plan was last updated on October 26, 2007. A face-to-face interview was conducted with Employee # 24 on March 6, 2008 at 2:15 PM. He/she acknowledged that the care plan was not updated with new goals and approaches after the above cited fall. The record was reviewed on March 6, 2008. 2. Facility staff failed to update Resident #17's care plan after a fall. A review of Resident #17's record revealed that the resident fell on September 10, 2007. The nurses note dated September 10, 2007 at 6:45 PM, "...Resident was sitting beneath the clock (in the nurses station) leaning to his/her left side and falling over the side of the wheel chair hitting his/her head..." The care plan "#11 Resident has history of falling" documented the aforementioned fall dated	F 280		

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F 280	Continued From page 17 September 10, 2007. There was no evidence in the record that new goals and approaches were initiated after the September 10, 2007 fall. A face-to-face interview was conducted with Employee #20 on March 7, 2008 at 10:00 AM. He/she acknowledged that new goals and approaches were not documented in the care plan after the fall on September 10, 2007. The record was reviewed on March 6, 2008.	F 280		
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 three (3) of 29 sampled residents, it was determined that facility staff failed to: reschedule a colonoscopy for one (1) resident, perform pacemaker checks as per physician's order for one (1) resident and accurately perform neurological checks for one (1) resident. Residents #5, 22 and 26. The findings include: 1. Facility staff failed to reschedule a colonoscopy procedure for Resident #5. A review of the resident's record revealed the following nursing notes:	F 309	1. Resident #5's colonoscopy was rescheduled on 3/6/08 and resident #22 was reassessed by the primary physician and the pacemaker check was completed on 3/18/08. Facility cannot retrospectively correct resident #26's neuro checks. 2. A review of all charts with pacemakers, colonos – copies and neurochecks has been done. No other residents were found to be affected by this practice. 3. Nursing personnel will be re-educated on consultations and follow-up appointments. Staff will also be in-serviced on protocol on neuro checks and pacemaker procedure 4. Monthly audits of appointments, neuro checks and pacemakers will be reported at Quality Improvement meetings.	4/25/08

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F 309	Continued From page 18 October 30, 2007 at 7:00 AM, "At 6:30AM, Writer was called by CNA [Certified Nursing Assistant] to take a look at resident's ****. It was very black in color. Writer tested it for occult blood and it was positive ...Resident appeared weak but stable ..." December 12, 2007 at 3:00 PM, " ...Colonoscopy scheduled for January 15, 2008 at 8:00 AM ..." January 14, 2008, "Colonoscopy [preparation] not done because consent form was not signed by responsible party. Will reschedule appointment and [follow-up with responsible party] ..." A doctor's telephone order of October 30, 2007 directed, "G.I. consult for positive stool guaiac." A "Gastrointestinal Consultation Report," signed by the physician and dated December 12, 2007 and January 16, 2008 directed "Colonoscopy ...see instruction and consent form ..." A face-to-face interview was conducted with Employee #8 on March 7, 2008 at approximately 11:00 AM. He/she acknowledged that the facility failed to reschedule the resident for the colonoscopy that was first ordered on December 12, 2007. The record was reviewed on March 7, 2008. 2. Facility staff failed to perform a pacemaker evaluation/assessment as ordered by the physician. A review of Resident # 22's record revealed a physician's order form signed and dated January 9, 2008 that directed, "Pacemaker check every 3 months: January, April. July, October".	F 309		

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F 309	Continued From page 19 A pacemaker's clinic consultation report in the resident's record revealed that the pacemaker was last evaluated on October 29, 2007. There was no evidence in the record that the resident had a pacemaker check in January as per the physician's order. A face-to-face interview was conducted with Employee # 8 on March 7, 2008 at approximately 11:00 AM. He/she acknowledged that the resident did not have a pacemaker check in January 2008 as per the physician's order. The record was reviewed March 7, 2008. 3. Facility staff failed to accurately perform neurological checks for Resident #26. A review of Resident #26 revealed the following nursing note dated December 5, 2007 at 10:35 PM, " Approx. 10:00 PM charge nurse reports hearing a noise. Upon investigation [charge nurse] found [Resident #26] with head and upper body on floor ... " A physician ' s telephone order dated December 5, 2007 at 10:00 PM directed, " Neuro checks (neurological) ... " A review of the " Neuro Flow Sheet " revealed that the resident ' s pupils were checked at 10:00 PM and 10:15 PM. Both pupils were assessed as being equal and reactive to light and measured 2 millimeters (MM). According to a " Report of Consultation " from the	F 309		

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F 309	Continued From page 20 Pupil O/S (left eye) 5 MM, nonreactive to light. Blind O/S with old retinal detachment... " A face-to-face interview was conducted with Employee #9 on March 6, 2008 at 2:30 PM. He/she acknowledged that the resident was not assessed accurately. The record was reviewed March 6, 2008.	F 309		
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. 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: missing skid strips on stairs, an extension cord in a resident's room, excessive items in residents' rooms and a electrical multi-plug on the floor in a resident's room. These observations were made on March 7, 2008 in the presence of Employees #1, 2 and 3 from 8:30 AM through 11:00 AM. The findings include: 1. The center stairs were observed with damaged skid strips. Residents were observed walking up and/or down the stairs on the following days: March 7, 2008 at 10:00 AM, March 8, 2008 at 12:30 PM and March 9, 2008 at 2:30 PM.	F 323	1. The skid strips identified on the center stairs were replaced. The extension cord was removed and replaced with a facility approved multi-plug unit which was secured to the wall. The multi-plug unit in room 423 was secured to the wall. The excessive items in the rooms identified have been secured. A meeting with the residents with excessive items was conducted by the Director of Social Work. All meetings were completed by 3/25/08. 2. All of the stair wells have been checked and no others were noted to not have skid strips. All rooms were rechecked for extension cords and /or multi-plug outlet not mounted and no others were identified. All rooms were checked for excessive items and no other rooms were found to be affected by this practice. 3. An inspection of skid strips will be added to engineer inspection sheet and replacement/repair will be made as indicates. Additionally, daily inspections are done of extension cords and excessive items. The Engineering Director met with the Admissions Department to coordinate efforts to ensure that new residents/families are aware that extension cords are prohibited, and excessive personal items must be secured. The nursing staff has been re-in-serviced to notify the Administration team when extension cords or excessive items are identified by the Engineering Director and is present in the monthly QA meeting. 4. The Engineering Director and Supervisors monitors the facility for safety issues. Any concern is corrected And reported to the Quality Assurance Meeting.	4/25/08

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F 323	Continued From page 21 2. An extension cord in room 228 was observed connected to the resident's personal entertainment equipment. 3. Excessive personal items were observed in rooms 103, 110, 119, and 214. 4. A multi-plug was identified as being used for a resident's electric wheel chair in room 423 and was observed on the floor. Employees #1, 2 and 3 acknowledged these findings at the time of the observations.	F 323		
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 observation, staff interview and record review for two (2) of 29 sampled residents, it was determined that the physician failed to follow up on a colonoscopy procedure for one (1) resident and a pacemaker check for one (1) resident. Residents #5 and 22. The findings include: 1. The physician failed to follow-up on a	F 386	1. Physician was notified regarding resident #5 and advised that colonoscopy was rescheduled on 3/6/08. Physician was also notified regarding resident #22, an assessment was done, and pacemaker check scheduled and completed on 3/18/08. 2. A review of all charts with pacemakers and colonoscopies was done. No other resident was found to be affected by this practice. 3. The Medical Director will re-educate the physician at the Medical staff meeting regarding physician services. 4. The Medical Director conducts audits of Medical services quarterly. This information is presented at the Quality Assurance Committee Meetings.	4/25/08

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F 386	Continued From page 22 colonoscopy procedure for Resident #5. A review of the resident's record revealed the following nursing notes: October 30, 2007 at 7:00 AM, "At 6:30AM, Writer was called by CNA [Certified Nursing Assistant] to take a look at Resident's stool. It was very black in color. Writer tested it for occult blood and it was positive ...Resident appeared weak but stable ..." December 12, 2007 at 3:00 PM, " ...Colonoscopy scheduled for January 15, 2008 at 8:00 AM ..." January 14, 2008, Colonoscopy [preparation] not done because consent form was not signed by responsible party. Will reschedule appointment and [follow-up with responsible party] ..." A doctor's telephone order of October 30, 2007 directed, "GI consult for positive stool guaiac." A GI [Gastrointestinal] consultation report signed by the physician and dated December 12, 2007 and January 16, 2008 directed "Colonoscopy ...see instruction and consent form ..." A face-to-face interview was conducted with Employee #8 on March 7, 2008 at approximately 11:00 AM. He/she acknowledged that the resident's record lacked evidence that the physician followed-up on the colonoscopy for Resident #5. The record was reviewed on March 7, 2008. 2. The physician failed to follow-up on a pacemaker check for Resident #22. A review of Resident #22's record revealed a physician's order form signed and dated January 9, 2008 that directed, "Pacemaker check every	F 386		

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F 386	Continued From page 23 three (3) months: January, April. July, October". A pacemaker's clinic consultation report in the resident's record revealed that the pacemaker was last evaluated in October 29, 2007. There was no evidence in the record that the resident had a pacemaker check in January as per the physician's order. The physician signed the February 2008 physician's order sheet for Resident #22 on March 5, 2008. There was no evidence in the record that the physician followed up on his/her order for the pacemaker check due in January 2008. A face-to-face interview was conducted with Employee #8 on March 7, 2008 at approximately 11:00 AM. He/she acknowledged that the resident's record lacked evidence that the physician followed-up with his/her order for pacemaker check. The record was reviewed March 7, 2008.	F 386		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	1. All expired medications were disposed of immediately. 2. All medication carts were reviewed and no additional expired medications were observed. 3. A meeting was held with the clinical team and pharmacy, and the clinical team was re-educated regarding importance of disposal of expired medication. 4. The nursing managers will evaluate/ audit the medication carts and provide information to Administration and /or Nursing Leadership monthly. This will be presented in QA meetings.	4/15/08

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F 425	Continued From page 24 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations on five (5) of six (6) nursing units, it was determined that the facility staff failed to dispose of expired medications. The findings include: On Tuesday, March 4, 2008 at approximately 1:00 PM and Wednesday, March 20, 2008 at approximately 3:00 PM an inspection of the facility's medication storage areas was conducted. All medication was observed in the medication carts. The tablets were packaged in blister packs. The following expired medications were found: 1 North Unit Plavix 75mg tab - expiration date of 1/3/2008 2 North Unit Glucagon Emergency Kit-expiration date of 6/2007 Albuterol nebulizers, 25/box-expiration date of 1/2008 Ipratropium nebulizers, 25/box-expiration date of 12/2007 Acetaminophen 325 mg tablets-expiration date of 8/2007 2 South Unit	F 425		

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	095036	A. BUILDING _____ B. WING _____	03/07/2008

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F 425	Continued From page 25 Acetaminophen 325 mg tablets, (3) packs-expiration date of 3/2007 Acetaminophen 325 mg tablets-expiration date of 12/2006 Acetaminophen 325 mg tablets, (2) packs-expiration date of 9/2007 Acetaminophen 325 mg tablets,(2) packs-expiration date of 7/2007 Acetaminophen 500 mg tablets-expiration date of 5/2007 Ibuprofen 200 mg tablets-expiration date of 10/2007 Prochlorperazine 10 mg tablets-expiration date of 12/2007 Diphenhydramine 25mg capsule-expiration date of 2/2008 4 North Unit Carbidopa/Levodopa 25/100 mg tablet-expiration date of 3/1/2008 Carbidopa/Levodopa 25/100 mg tablet-expiration date of 3/1/2008 Docusate Sodium 100 mg capsules, (3) packs-expiration date of 1/2008 Docusate Sodium 100 mg capsules-expiration date of 11/2007 Fexofenadine 180 mg tablets-expiration date of 3/1/2008 4 South Unit Ferrous Sulfate 325 mg tablets-expiration date of 10/2007 Oyster Shell tablets-expiration date of 12/2007 Bisacodyl 5mg tablets-expiration date of 9/2007 Acetaminophen 325 mg tablet, (3) packs-expiration date of 10/2007 Acetaminophen 325 mg tablet-expiration date of 8/2007	F 425		
F 456	483.70(c)(2) SPACE AND EQUIPMENT	F 456		

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F 456 SS=D	Continued From page 26 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that equipment was not maintained in safe operating condition as evidenced by: condensation between the glass panes of windows, damaged and rusted water fountains, and washers that vibrated during the spin cycle. These observations were made on March 7, 2008 in the presence of Employees #1, 2 and 3 from 8:30 AM through 11:00 AM. The findings include: 1. The 4S library window and hallway windows were observed with condensation between the glass panes. 2. The water fountains on the 2nd, 3rd and 4th floors were observed with rusted areas on the bottoms of the fountains. 3. The facility laundry washing machines were observed to vibrate and the vibrations could be felt in the laundry and on the 1st floor above the machines, while the machines were in the spin cycles. Employees #1, 2 and 3 acknowledged these findings at the time of the observations.	F 456	1. An independent window contractor will be contacted regarding the large fixed picture windows and submit a proposal for corrective action. No resident was impacted by this practice. It did not constitute a safety hazard for the residents of the facility it is purely an aesthetic issue which we will resolve. The water fountains on the 2nd 3rd and 4th floor have been reviewed and as noted the small amount of rust at the base will be repaired and/or replaced. A request has been submitted to the general contractor and the DC government department responsible for the installation of the new washing machines. They are currently reviewing the design designated to determine proper course of action. 2. All large fixed picture windows in the facility was checked and no other windows were noted to have condensation between the glass panes. All water fountains were checked and no other water fountain were impacted by this practice. The facility will work closely with the design engineer and equipment manufacturer for all washing machines. 3. Daily environmental inspection will be done on windows and water fountains. Additionally, the facility will continue to work closely with the DC Government Contract Office and make an earnest attempt to have them involve the facility with the selection of equipment and specification. 4. The Engineering Department will monitor the environmental and new construction in the facility. The information is reported in the Quality Assurance meeting.	4/25/08
F 469 SS=E	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL	F 469		

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F 469	Continued From page 27 The facility must maintain an effective pest control program so that the facility is free of pests and rodents. 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 pest free environment as evidenced by crawling and/or flying insects observed throughout the facility. These observations were made in the presence of Employees #1 and 2. The findings include: On March 4, 2008, pests were observed as follows: A crawling insect at 9:00 AM near room 119. A crawling insect at 9:40 AM near room 419. A gnat at 12:25 PM in the1N soiled utility room. A gnat at 2:00 PM in room 215. A dead insect at 3:15 PM in room 221. A gnat at 3:30 PM in room 230. On March 5, 2008, pests were observed as follows: A gnat at 8:30 AM, 3N entrance way. A gnat at 10:00 AM in the doorway of room 407. A gnat at 12:30 PM in the basement hallway by the elevators. Employees #1 and 2 acknowledged these findings at the time of the observations.	F 469	1. Western Pest Control was at the facility during the survey for their regularly schedule inspection. They immediately treated the areas that were reported on gnats and 2 crawling insect were observed. 2. The facility was checked and all rooms were found to be free of insects. 3. The facility has a detailed pest control program. Staff has been in-serviced. Additionally Contractors who are doing construction have been reminded not to leave windows open and replace screens if they need to remove them. 4. The Director of Environmental Services and Supervisors monitors the facility for insects. This information is logged and used by the Pest Control Contractor. The outcome is reported to the Quality Improvement Team quarterly.	4/11/08
F 492 SS=D	483.75(b) ADMINISTRATION	F 492		

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F 492	Continued From page 28 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, it was determined that facility staff failed to ensure that the dietician was licensed in the District of Columbia and that the temperature of cold foods did not exceed 45 degrees Fahrenheit (F) and hot foods were served above 140 F at the point of delivery to the resident. The findings include: 1. Facility staff failed to ensure that the dietician was licensed in the District of Columbia. According to 22DCMR 3203.2, "A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director." A review of the facility's licenses revealed that the dietician did not have a license from the District of Columbia. A face-to-face interview was conducted with the dietician on March 7, 2008 at 11:30 AM. He/she stated, "I am registered with the Commission on Dietetic Registration of the American Dietetic Association. I did not know that I needed a license from the District of Columbia."	F 492	1. The Dietician is licensed by the Commission on Dietetic Registration. All paperwork was submitted to the District of Columbia Licensing Body and she has received a DC license. Facility staff reheated food items prior to serving. Facility cannot retrospectively correct the varying temperature on test tray. 2. All licenses were checked and no other staff was employed without DC license. A review of the meal schedule was done to ensure residents trays are passed in a timely manner. No other residents were affected by this practice. 3. The Dietary Staff were notified that license must be maintained with both Dietetic Registration and The District of Columbia. Nursing personnel will be in-serviced on the meal schedule and passing food trays. 4. Monitoring of Licenses are completed by the Human Resources Department monthly and reported to Quality Assurance. Monthly audits of meal schedule and passing trays will be reported at the Quality Improvement meeting.	3/31/08

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F 492	Continued From page 29 2. Facility staff failed to ensure that the temperature of cold foods did not exceed 45 degrees Fahrenheit (F) and hot foods were served above 140 F at the point of delivery to the resident. According to 22 DCMR 3220.2, "The temperature for cold foods shall not exceed forty-five (45) Fahrenheit and for hot foods shall be above one hundred and forty degrees (140) Fahrenheit at the point of delivery to the resident." On March 4, 2008, trays were delivered to unit 4 North at 8:50 AM. The last tray was passed to the residents at 9:50 AM. The test tray was checked and the following food temperatures were recorded in the presence of Employee #9: 2% Milk - 61.6 F Apple Juice - 58.6 F Scrambled Eggs - 88.1 F Bacon - 80.4 F Toast - 81.0 F Employee #9 acknowledged the findings at the time of the observations.	F 492		