Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0016	A. BUILDING: _____ B. WING _____	05/23/2014

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) COMPLETE DATE
L 000	Initial Comments A Licensure Survey was conducted on May 20, 2014 through May 23, 2014. The deficiencies are based on observations, interview and record review for 21 sampled residents. Glossary: ARD- Assessment Reference Date MAR-Medication Administration Record MDS-Minimum Data Set QIS-Quality Indicator Survey	L 000	1. The two (2) out of eight (8) fire suppression plastic covers were immediately cleaned and sanitized and free of debris on 5.20. 2014. 2. All other fire suppression covers in the kitchen were inspected and all were in compliance. 3. All dietary staff were in serviced on 6.16.14 on cleaning suppression plastic covers which will be done daily as part of the dietary closing checklist. *(See Appendix B)* 4. Dietary Supervisors will check and monitor compliance monthly and randomly. All findings will be reported to the monthly Safety and Infection meetings and QA quarterly meeting. 5. Corrective action was completed on	6.16.2014
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on May 20, 2014 at approximately 10:00 AM, it was determined that the facility failed to prepare food under sanitary condition as evidenced by two (2) of eight (8) fire suppressors noted with soiled plastic covers. The findings include: 1. Two of eight fire suppression outlet plastic covers were visibly soiled with debris and needed to be cleaned or replaced. This observation was made in the presence of Employee #1 and Employee #3 who acknowledged the findings on May 20, 2014.	L 099	1. The physician's ophthalmic orders were clarified and transcribed accurately on 5. 21.2014. Resident #28 was not reported or observed to have been harmed by this deficient practice. 2. Medication Administration Records were audited and no other resident was affected by this deficient practice. 3. New orders are noted, reviewed and transcribed by charge nurses and will make clarification of orders as necessary. New orders will also be reviewed and audited by the night shift charge nurses which will be included in the 24 hour report. An in-service was given to the nurses on obtaining telephone orders, clarifying orders and accurate transcription of orders on 6.12.2014. *(See Appendix C)*	
L 199	3231.10 Nursing Facilities	L 199		

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L 199	Continued >From page 1 Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 21 sampled residents, it was determined the facility staff failed to maintain the clinical record in accordance with accepted professional standards and practices as evidenced by failure to accurately transcribe medication orders and document medication administration in accordance with acceptable professional standards. Residents #28 and 29 The findings include: 1. The facility staff failed to accurately transcribe three ophthalmic medication orders on the May 2014 Medication Administration Record (MAR) for Resident #28. A review of the clinical record revealed that Resident #28's diagnoses included Glaucoma. Physician's Order dated May 17, 2014 revealed the following: " 5/17/14 Pred Forte 1% one drop 4x daily x 10 days to R [right] eye " "5/17/14 Ketorolac one drop 4x daily x 10 days to R [right] eye" "5/17/14 Vigamox one drop 4x daily x 10 days to R [right] eye" A review of the May 2014 Medication Administration Record revealed that the	L 199	4. ADON/DON and QA nurse will do a monthly and random check of Physician's Orders and Medication Administration Records. All findings will be reported to the QA quarterly meetings. 5. The corrective action was completed on 6.12.2014.	6.12.2014

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L 199	Continued >From page 2 transcribed orders lacked the 'route' [eye] of administration as stipulated in the physician's orders as follows: " 5/17/14 Pred Forte 1% one drop 4x daily x 10 days right" "5 /17/14 Ketorolac one drop 4x daily x 10 days right" "5/171/4 Vigamox one drop 4x daily x 10 days right" A face to face interview was conducted on May 21, 2014 at 12:20 PM with Employee #10 and Employee #7. Both acknowledged the aforementioned findings. Facility staff failed to accurately transcribe medications in accordance with physician's orders for Resident #28. The clinical record was reviewed May 21, 2014. 2. Facility staff failed to document the administration of medication in accordance with accepted standards of professional practice. In accordance with Agency for Healthcare Research Quality, Patient Safety Resource dated May 4, 2014, "Why medication administration errors occur" stipulates "...Failure to follow policies and procedures results in lack of attention to safeguards intended to prevent errors in medication administration procedures..." Little Sisters of the Poor's policy Medication Administration dated February, 2010 stipulates: "PROCEDURES ...9. Initial each medication in	L 199	1. Resident #29 was not observed or reported to have been harmed by this deficient practice. An in-serviced was given to the nurse on 5.22.2014 on Medication Administration Policy and Procedure. 2. No other resident is affected by this deficient practice. Nurses were in-serviced on Medication Administration Policy and Procedure on 6.12.2014. *(See Appendix C)* 3. All new nurses will be observed on medication pass during orientation and a Medication pass observation will be done quarterly on each charge nurse using the Medication pass Survey tool. 4. ADON/DON and QA nurse will do a random and monthly medication pass observation on nurses. All findings will be reported in the quarterly QA meetings. 5. Corrective action was completed on 6.12.2014. 1. The surge protector that was found on the floor in room #1401 was permanently mounted on the wall on 5.26.2014. Resident was not reported or observed to have been harmed by this deficient practice. 2. All rooms on both units were inspected and they are all in compliance. No other resident is affected by this deficient practice.	**6.12.2014**

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L 199	Continued >From page 3 the correct box in the MAR as each medication after administration ...14. Circle initials on MAR if medication is not administered as ordered and record reason on MAR... " Resident #29 was admitted to the nursing facility with diagnoses which included Hypertension, Dementia, Depression, Arthritis, and Glaucoma. During a staff interview with Employee # 6 on May 21, 2014 at 10:15 AM, Employee #11 entered the room and requested the Medication Administration Record for Resident #29. Employee #11 informed Employee #6 that Resident #29 was experiencing pain. After reviewing the Medication Administration Record, Employee #11 initialed the Medication Administration Record in the space allotted to record the administration of medication [Tylenol]. Employee #11 stated, "I will sign it off now. If [he/she] does not take it, I will come back and circle it... " Subsequent review of the Medication Administration Record confirmed that Employee #11 initialed the Medication Administration Record prior to obtaining and administering the medication.. Tylenol 1000 milligrams by mouth was signed as given on May 21, 2014 at 10:15 AM, by Employee #11 prior to its administration. A face-to-face interview with Employee #11 was conducted on May 22, 2014 at approximately 3:45 PM. During the interview, Employee #11 confirmed and acknowledged the aforementioned observation. The facility staff failed to meet professional standards and the facility's policy related to medication administration.	L 199	3. All nursing staff will be in-serviced on the proper use of surge protectors on 6.25.2014 and to notify maintenance department for any electrical needs. 4. Unit Supervisor will do a monthly room and unit inspection. Maintenance Department Supervisor and QA nurse will do a random unit and room inspection. All findings will be reported to the monthly Safety and quarterly QA meetings. 5. Corrective action will be completed by 6.25.2014. 1. The extension cord with 3 occupied outlets found in the rehabilitation room that is a tripping hazard was replaced with surge protector that was permanently secured and mounted to the wall on 5.26.2014. 2. The entire rehabilitation room was inspected and no other cord was found deficient. No resident was observed or reported to have been harmed by this deficient practice. 3. An in-service was given to the rehabilitation staff to keep all cords off the floor and to notify maintenance for all electrical needs on 5.26.2014. 4. Rehabilitation Department Supervisor will inspect rehabilitation room monthly. Maintenance Department supervisor and QA nurse will monitor and inspect rehabilitation room randomly. All findings will be reported to the monthly Safety and quarterly QA meetings. 5. Corrective action was completed on 5.26.2014	6.25.2014 5.26.2014

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L 199	Continued >From page 4 The findings were discussed with and acknowledged by Employee#6 and Employee #11 on May 22, 2014 at 3:45 PM.	L 199	1. The call bell cords that were found deficient were immediately corrected on 5.20.2014. No resident was observed or reported to have been harmed by this deficient practice. 2. All call bell cords in the residents' rooms were inspected and cut short just enough to freely dangle without touching the floor. All other call bell cords were found in compliance. 3. Staffs were in-serviced on 5.21.2014 on keeping call bell cords freely dangling at all times ensuring that they are not wrapped around the grab bars. 4. Unit Supervisor will monitor call bell cords monthly. QA nurse and Maintenance Department Supervisor will check call bell cords randomly. All findings will be reported to the monthly Safety and quarterly QA meetings. 5. Corrective action was completed on 5.21.2014	**5.21.2014**
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on May 20, 2014 at approximately 3:00 PM, it was determined that the facility failed to maintain resident's areas free of accident hazards as evidenced by a surge protector observed on the floor of one (1) of 19 resident rooms, an extension cord being used in one (1) of one (1) Physical Therapy unit and call bell cords that were wrapped around the grab bar in three (3) of 19 resident's rooms. The findings include: 1. A surge protector was observed in use, on the floor of resident room #1401 and presented a tripping hazard. 2. An extension cord with three (3) occupied outlets was stored on the floor of the rehabilitation room and presented a tripping hazard. 3. Call bell cords were wrapped around the grab bar in such a manner as to prevent them from	L 214		