Little Sisters of the Poor

Jeanne Jugan Residence
4200 Harewood Road, N.E.
Washington, DC 20014-1511

May 17, 2016

Dr. Sharon Williams Lewis
Program Manager
Government of the District of Columbia
Department of Health
Health Regulations and Licensure
899 North Capital Street N.E.
Washington, DC 20002

Dear Dr. Sharon Lewis,

We are submitting for your approval our Plan of Correction (POC) for the deficiencies cited at the completion of the Recertification Quality (QIS) and Licensure Survey conducted by surveyors from CMS and the Department of Health from April 13, 2015 to April 20, 2015.

We hope this POC will bring us into compliance with the participation requirements as we strive to provide the best of care, happiness and comfort for the Residents of the Little Sisters of the Poor (Jeanne Jugan Residence) so as to continue living the spirit and love of our saintly Mother St. Jeanne Jugan.

Please do not hesitate to contact me if you have any questions or concerns. I can be reached at the following:

Phone: 202-269.1831
Cell: 202-604-5622
Email: admwashington@littlesistersofthepoor.org

We thank you and your survey team for your assistance.

Sincerely,

Sr. Celestine Meade, lsp

Sr. Celestine Meade
Administrator

Enclosure: CMS-2567
State Form 6899

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 ______	04/20/2015

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	F 164		

INITIAL COMMENTS

A recertification Quality Indicator Survey was conducted April 13 through 20, 2015. The deficiencies are based on observation, record review, resident and staff interviews for -3-5 sampled residents.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor

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

A. Celestine Meade, LNHA — Administrator — 5/18/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 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 room for each resident. Except as provided in paragraph (e)(3) of this	F 164		

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F 164	Continued From page 2 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 observation and staff interview for one (1) of 35 sampled residents, it was determined that facility staff failed to promote privacy for Resident #39 as evidenced by a licensed nurse observed performing a blood glucose assessment in the common room in the presence of five (5) other residents and two (2) visitors. The findings include: On April 17, 2015 at approximately 4:00 PM Employee # 7 was observed in the Good Shepherd dayroom obtaining blood from Resident # 39's finger. After Employee #7 performed the blood glucose test he/she then verbalized the test results to the resident. At the time of the observation, five (5) residents and two (2) visitors were present in the dayroom. A face-to-face interview was conducted with	F 164	1. Resident #39 was not observed or reported to have been harmed by this deficient practice. An in service was given on 4/17/15 to Employee #7 on promoting privacy and confidentiality when a medical treatment is performed. 2. No other resident is affected by this deficient practice. 3. An in service was given to all license nurses on 4/21/15 until 4/30/15 on Promoting Privacy and Confidentiality for all residents anytime a medical treatment is provided or performed. A Resident's rights in- service is given annually to all staff by SW. 4. DON/ADON or designee will do a random check and observation weekly on licensed staff on different shifts. All findings will be reported to the Monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/30/15.	**4/30/15**

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F 164	Continued From page 3 Employee # 7 at the time of the observation. He/she acknowledged the findings. There was no evidence that facility staff provided privacy to Resident #39 when performing a blood glucose assessment.	F 164		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations during the initial tour, it was determined that facility staff failed to display survey results in a location readily accessible to residents that utilize wheelchairs as a primary mode of transportation and failed to post a notice of the availability of the survey results. The findings include: On Tuesday April 14, 2015 at approximately 10:00 AM, a tour of the nursing units was conducted. It was noted that the survey results on the Good Shepherd and Sacred Heart Units were placed in a file slot on the wall which was out of reach to residents seated in a wheelchair.	F 167	1. No resident has been reported or observed to have been harmed by this deficient practice. 2. Slots assigned for Survey Reports on both units *(Good Shepherd and Sacred Heart)* were adjusted to eye level for wheelchair bound residents on 5/7/15. 3. A larger signage was placed on the survey slots for Residents to easily notice and access. 4. Random checks will be made by Administrator. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 5/7/15.	**5/7/15**

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F 167	Continued From page 4 In addition, there was no notice of survey result(s) visibly posted in a location accessible to individuals wishing to examine the results, without having to ask to see them. The findings were acknowledged in the presence of Employees #2 and 3. There was no evidence that facility staff displayed survey results in place readily accessible to residents that utilized wheelchairs as a primary mode of transportation and failed to post a notice of their availability.	F 167		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	FINDING #1. 1. Resident #16 was not observed or reported to have been harmed by this deficient practice. Annual Minimum Data Set was modified on 4/22/15 and Vascular Dementia was added to Section I. 2. An audit was done on all Section I of residents with completed MDS. Residents who were found deficient were not reported or observed to have been harmed by this practice. Employee #5(MDS Coordinator) reviewed the RAI manual on coding Section I on 4/22/15. 3. MDS Coordinator will review all residents' consultation forms and list of diagnosis thoroughly and code section I accurately based on the RAI manual before submitting completed MDS. 4. A random and monthly audit will be done by DON/ADON or designee to ensure compliance. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action completed on 4/22/15.	4/22/15

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F 272	Continued From page 5 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 35 sampled residents, it was determined that facility staff failed to accurately code the minimum data set (MDS) for: one (1) resident with a diagnosis of schizoaffective disorder, one (1) resident with a diagnosis of vascular dementia, and one (1) resident with diagnoses of Alzheimer ' s Disease, Depression and Anxiety Disorder. Residents' #16, 39 and 41. The findings include: 1. Facility staff failed to accurately code Section I [Active Diagnosis] of the annual MDS for depression for Resident #16. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of December 8, 2014 revealed that under Section I the resident was coded as having Alzheimer's disease.	F 272	FINDING #2 1. Resident #39 was not reported or observed to have been harmed by this deficient practice. Quarterly MDS was modified and submitted on 4/17/15 and Schizoaffective Diagnosis was added to Section I. 2. All residents' completed and submitted MDS were reviewed and audited by MDS Coordinator focusing on Section I. Residents who were found deficient were not reported or observed to have been harmed by this deficient practice. Employee #5(MDS Coordinator) reviewed the RAI manual on coding Section I on 4/17/15. 3. MDS Coordinator will review all residents' consultation forms and list of diagnosis thoroughly and code section I accurately based on the RAI manual before submitting completed MDS. 4. A random and monthly audit will be done by DON/ADON or designee to ensure compliance. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action completed on 4/17/15.	**4/17/15**

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F 272	Continued From page 6 According to a " Medical Examination " dated April 17, 2014 Resident # 16 ' s active problems included: Dementia with Agitation and Depression. A " Psychiatric Evaluation " dated September 12, 2014 revealed that the resident was on the following psychotropic medications: Aricept 10 mg every hour of sleep for memory loss, Remeron 7.5mg every hour of sleep for Depression... Psychiatric Diagnosis: Vascular Dementia with Depression. " There was no evidence that facility staff coded the resident for depression on the annual MDS. A face-to-face interview was conducted with Employee #5 on April 20, 2015 at approximately 12:00 PM regarding the aforementioned finding. He/she acknowledged the annual MDS was not coded to reflect the resident 's diagnosis of vascular dementia. The clinical record was reviewed on April 20, 2015. 2. Facility staff failed to accurately code Section I [Active Diagnosis] of the quarterly MDS for Resident #39 with a diagnosis of schizoaffective disorder. The physician ' s order dated January 19, 2015 directed, "Abilify 5 mg take one (1) tablet by mouth at bedtime for schizo-effective disorder." A review of the psychiatric consultation dated November 14, 2014 revealed that Resident #39 ' s diagnoses included " schizoaffective disorder, depressed type. " A review of the quarterly MDS completed January	F 272	FINDING #3 1. Resident # 41 was not reported or observed to have been harmed by this deficient practice. Quarterly MDS was modified and submitted on 4/17/15. Depression and Psychosis were added to Section I. 2. All residents' completed and submitted MDS were reviewed and audited by MDS Coordinator focusing on Section I. Residents who were found deficient were not reported or observed to have been harmed by this deficient practice. Employee #5(MDS Coordinator) reviewed the RAI manual on coding Section I on 4/17/15. 3. MDS Coordinator will review all residents' consultation forms and list of diagnosis thoroughly and code section I accurately base on the RAI manual before submitting completed MDS. 4. A random and monthly audit will be done by DON/ADON or designee to ensure compliance. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action completed on 4/17/15.	**4/17/15**

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F 272	Continued From page 7	F 272		

23, 2015 revealed that the resident's diagnosis of schizoaffective disorder of the depressed type was not coded under Section I.

A face-to-face interview was conducted with Employee #5 on April 17, 2015 at approximately 12:50 PM. He/she acknowledged the findings. The record was reviewed on April 17, 2015.

3. Facility staff failed to code Section I, Active Diagnosis, of the quarterly MDS for Depression and Psychosis for Resident #41.

A.) A review of the quarterly MDS dated March 12, 2015 for Resident #41, lacked evidence of coding for the active diagnosis of Depression.

Physician ' s orders dated December 31, 2014 directed, " Increase Remeron 15mg po qhs [by mouth at hour of sleep for] depression."

A review of the Psychiatric Evaluation record dated October 23, 2014 revealed, " FU [follow up] psych eval [evaluation]. The patient is 87 yo [years old] ... with a hx of dementia with depression ... "

A review of the Psychiatric Evaluation dated March 18, 2015 revealed a Psychiatric Hx [history] that noted, " This is a follow up psych evaluation. ... with a hx of dementia ... psychiatric diagnosis was Dementia with depression ... "

A review of the quarterly MDS signed March 12, 2015 revealed that Depression was not coded under section I.

A face-to-face interview was conducted on April

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20, 2015 at approximately 10:30AM with Employee # 5. After reviewing the MDS he/she acknowledged the findings and stated that a correction would be made. The record was reviewed on April 20, 2015.

B.) The quarterly MDS dated March 12, 2015 lacked evidence of coding for the active diagnosis of Psychosis for Resident #41.

A review of the psychiatric evaluation dated March 18, 2015 revealed, " Psychotropic Medications ...Risperdal 1MG [milligram] PO QD [everyday] ...Indication - psychosis ..."

A review of the quarterly MDS completed March 12, 2015 revealed that under Section I , the diagnosis of Psychosis was not coded..

A face-to-face interview was conducted on April 20, 2015 at approximately 10:30AM with Employee # 5. After reviewing the MDS he/she acknowledged the findings and stated that a correction would be made. The record was reviewed on April 20, 2015.

F 279 SS=D

483.20(d), 483.20(k)(1) DEVELOP 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.

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F 279	Continued From page 9 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 two (2) of 35 sampled residents, it was determined that facility staff failed to initiate care plans with goals and approaches to address two (2) residents ' medication allergies. Residents ' #18 and #36. The findings include: 1. Facility staff failed to address Resident #18 ' s medication allergy history to Ace Inhibitors (drug used primarily for the treatment of hypertension), Angiotensin Receptor Blockers (drugs used for controlling high blood pressure, treating heart failure and preventing kidney failure) and NSAIDS (Non-steroidal Anti-Inflammatory Drugs - analgesic medication that reduces pain, fever and inflammation). The " Physician ' s Order " signed and dated February 12, 2015 revealed, " Allergies: Ace Inhibitors, Angiotensin Receptor Blockers and NSAIDS " A review of the clinical record for Resident #18	F 279	FINDING # 1 1. Resident #18 was not reported or observed to have been harmed by this deficient practice. Allergy care plan with goals and interventions was added to reflect resident's allergy to Ace Inhibitors, Angiotensin Receptor blockers, and NSAIDS on 4/17/15. 2. An audit was done on all residents' care plans with allergies by MDS Coordinator which was completed on 4/23/15. Residents who were found deficient were not reported or observed to have been harmed by this practice. 3. MDS Coordinator was in-serviced on 4/23/15 on care planning allergies for all residents. 4. A weekly and random check or audit of care plans will be done by DON/ADON or designee. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 4/23/15.	4/23/15

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F 279	Continued From page 10 lacked evidence that a care plan was initiated with goals and approaches to address the specific history of medication allergies to Ace Inhibitors, Angiotensin Receptor Blockers and NSAIDS. A face-to-face interview was conducted with Employee #3 on April 17, 2015 at approximately 11:30 AM. He/she acknowledged that there was no care plan in place to address the resident 's allergies. The record was reviewed on April 17, 2015. 2. Facility staff failed to initiate a care plan with goals and approaches to address Resident #36 ' s allergy to Penicillin (antibiotic). A review of the history and physical examination signed and dated May 29, 2014, revealed: "Allergies: Penicillin." The MAR (Medication Administration Records) dated January through April 2015 revealed; " Allergies: Penicillin. " A review of the clinical record for Resident #36 lacked evidence that a care plan was initiated with goals and approaches to address the specific medication allergy to Penicillin. A face-to-face interview was conducted with Employee #3 on April 17, 2015 at approximately 11:30 AM. He/she acknowledged that there was no care plan in place to address the resident 's medication allergy history. The record was reviewed on April 17, 2015.	F 279	FINDING # 2 1. Resident #36 was not reported or observed to have been harmed by this deficient practice. Allergy care plan with goals and interventions was added to reflect resident's allergy to Penicillin on 4/17/15. 2. An audit was done on all residents' care plans with allergies by MDS Coordinator which was completed on 4/23/15. 3. Residents who were found deficient were not reported or observed to have been harmed by this practice. MDS Coordinator was in-serviced on 4/23/15 on care planning allergies for all residents. 4. A weekly and random check or audit of care plans will be done by DON/ADON or designee. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 4/23/15.	4/23/15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			

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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 record review and staff interview for two (2) of 35 sampled residents, it was determined that facility staff failed: to clarify orders for fluid restrictions for one (1) resident with End Stage Renal Disease; and to administer Psychotropic medication to one (1) resident, as directed by the physician. Residents ' #18 and 31.

The findings include:

1. Facility staff failed to clarify an order for fluid restriction for Resident #18 who has a diagnosis of End Stage Renal Disease.

A review of the medical record revealed that Resident #18 was readmitted to the facility on February 27, 2015 with diagnoses that included: Pulmonary Edema, Volume Overload and End Stage Renal Disease.

A review of physician's orders signed and dated April 16, 2015 directed, "Diet Orders: Fluid Restriction 1500 ml; 11-7= 100ml, 7-3= 400ml, 3-11 = 600ml [order originated February 27, 2015].

FINDING #1.

1. Resident #18 was not observed or reported to have been harmed by this deficient practice.
2. All other residents with fluid restriction orders were reviewed and the facility is found to be in compliance.
3. Fluid restriction order of Resident #18 was clarified with Primary Physician in collaboration with the dietician to reflect the accurate breakdown of the fluids within a 24 hour period to equal 1500ml/daily. An In-service was given to licensed staffs on the accurate breakdown of 1500ml/daily fluid restriction of resident #18 on 4/20/15.
4. Monthly "Intake and Output Chart" will be checked and monitored by DON/ADON or designee. All findings will be reported to the Department Head monthly meetings and quarterly QAPI meetings.
5. Corrective action was completed on 4/20/15. — **4/20/15**

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	09E020	A. BUILDING ____ B. WING ____	04/20/2015

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 309	Continued From page 12 Although the fluid restriction order stipulates 1500 ml ' s, the breakdown of fluid of amounts over a 24 hour period [11-7, 7-3, 3-11] equaled 1100ml ' s. A Review of the Medication Administration Record [MAR] for February 2015 revealed the resident received the following: " Fluid Restrictions 1500 ml daily- 11-7 = 100, 7-3=400ml, 3-11 = 500ml as evidenced by the nurses' initials in the allotted spaces. However, the amount allotted for each shift totaled 1000 ml for every 24 hours. A review of the " Intake and Output Chart " flow sheets for the months of March 2015 and April 2015 revealed that Resident #18 had an oral intake ranging from 900ml to 1100 ml of fluid every 24 hours. A review of the medical record lacked evidenced that the physician's order was clarified to verify the amount of fluid Resident #18 was to receive in a 24-hour period. A face-to-face interview was conducted with Employees #2 and 9 on April 20, 2015 at approximately 1:00 PM. After reviewing the clinical record, both acknowledged the aforementioned finding. The clinical record was reviewed on April 20, 2015. 2. Facility staff failed to administer Resident #31's psychotropic medication, as directed by the physician. Physician's orders dated October 24, 2014 directed, " Escitalopram [Lexapro] tab [tablet] 20 mg [milligrams], take one tablet by mouth every	F 309	FINDING #2. 1. Resident # 31 was not reported or observed to have been harmed by this deficient practice. 2. All Medication Administration Records of residents who are receiving psychotropic medications were reviewed and the facility is found to have been compliant. Deficient employee was in serviced on the Policy and procedure on Medication Administration on 4/20/15. 3. An in-service on the Policy and Procedure of Medication Administration was completed on 4.30.15 to all nursing licensed staff. An in service on the Policy and Procedure on Medication Administration will be given to all new Licensed Nursing staff during orientation and annually. 4. A monthly random check and audit of the Medication Administration Record will be done by DON/ADON or designee. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action completed on 4/30/15.	**4/30/15**

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F 309	Continued From page 13 morning for Anxiety." A review of the March 2015 Medication Administration Record [MAR] revealed that on March 22, 2015 at 8:00AM, the space allotted to indicate that the Lexapro was administered was left blank [indicating that the medication was not given]. There was no evidence that on March 22, 2015 at 8:00AM, the facility staff administered Lexapro to Resident #31, as ordered by the physician. A face-to-face interview was conducted on April 20, 2015 at approximately 10:30 AM with Employee # 3 regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on April 20, 2015.			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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: A. Based on observations made on April 14, 2015 , it was determined that facility staff failed to ensure resident ' s environment was free of accident hazards as evidenced by a radiator heater and shredder observed in two (2) of 16 resident rooms.	F 323	FINDING A1 1. Resident in Room # 1223 Good Shepherd Unit was not reported or observed to have been harmed by this deficient practice. 2. All residents' rooms in the facility were checked/inspected, no other electric radiator heater was found/noted and the facility is found to be in compliance. 3. a). The electric radiator heater in Room #1223 was removed immediately on 4.14.15 with the resident and family's consent. b). Upon admission into the facility, all new residents will be made aware that electric radiator heater is not permitted. 4. Maintenance department will do a monthly and random check of each resident's room for compliance. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/14/15.	4/14/15

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The findings include:

1. One [1] of [1] electric radiator heater was observed plugged into wall outlet [but not in use] in room #1223 [Unit - Good Shepherd] on April 14, 2015 at approximately 9:30 AM.

2. One [1] of [1] electric paper shredder was observed in room 1216-1 (Unit - Good Shepherd) on April 14, 2015 at approximately 11:12 AM.

These observations were made in the presence on Employee #3 who acknowledged the findings. The heater and shredder were immediately removed from the resident ' s rooms.

The engineering staff stated they were unaware of the presence of the radiator heater and the shredder in the residents' rooms.

B. Based on observation, record review and staff interview, it was determined that facility staff failed to ensure residents' were free of potential accident hazards, as evidenced by the application of hydrocollator packs [moist heat] by one (1) of four (4) staff persons [Restorative Aides] that was not trained in the use of moist heat therapy.

The findings include:

According to the facility's " Restorative Nursing " policy dated December 2010, "The Director of Nursing has overall responsibility for the restorative nursing care program in accordance with nursing policies and procedures. (a). The Department Head is responsible for monitoring

FINDING A2

1. Resident in Room #1216-1 Good Shepherd Unit was not observed or reported to have been harmed by this deficient practice.
2. All residents' rooms in the facility were checked/inspected; no other electric paper shredder. Facility is found to be in compliance.
3. *a)* The electric paper shredder in Room 1216-1 Good Shepherd unit was inspected by the maintenance department on 4/15/15 and was removed immediately with resident's consent since appliance was not functional.

   b) Upon admission to the facility; all new residents will be made aware that all new electrical equipment/appliance (excluding electric radiator heater) will be inspected and cleared by maintenance department before initial use by the resident.

   c) Nursing care plan will be initiated
4. Maintenance Department will keep a log of each resident's electrical appliance that they have inspected and cleared. A monthly and random inspection will be made in resident's rooms to ensure compliance. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings.
5. Corrective action was completed on 4/15/15.

4/15/15

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F 323	Continued From page 15 the nursing staff in carrying out the program. (b). The in-service Director is responsible for training all nursing staff in restorative nursing techniques by providing group classes and/or one-on-one teaching sessions ... " During an environmental tour of the Rehabilitation Department with Employee #6 on April 20, 2015 at approximately 10:00 AM, Two (2) hydrocollator machines were in use. A " Hot Pack Treatment Chart " was observed on a ledge, proximal to the hydrocollator machine. A query was made to Employee #8 regarding whether or not any residents were receiving heat therapy and if so, who was responsible for administering the treatment? Employee # 8 stated, "Yes, " the residents listed on the Hot Pack Treatment Chart were receiving heat therapy and the Restorative Aides were trained to apply the hot packs. Through face-to-face interview with Employee #4 on April 20, 2015 at approximately 2:00 PM, it was determined that four (4) Restorative Aides had duties that included the application of heat therapy via " Hot Packs. " A review of clinical records revealed eleven (11) residents had physician orders for the application of hot pack treatments. The facility ' s in-service education records revealed three (3) Restorative Aides underwent training on " Hydrocollator Usage " according to training documents dated July 10, 2014. However, there was no documentation to support that Employee #13 [Restorative Aide] underwent in-service education/ training on hydrocollator usage.		B. 1. Residents who received hydrocollator packs/hot packs have not been reported or observed to have been harmed by this deficient practice. 2. An in-service was given to employee #13 on Hydrocollator Usage on 4/30/15. 3. *a).* All new restorative nurses and restorative aides will be given an in-service and training on Hydrocollator usage before they are allowed to use hot packs/hydrocollator packs. *b).* A skill competency checklist for restorative aides or restorative nurses will be utilized and checked off upon employment and annually. 4. DON/ADON or designee will do a monthly and random check on accurate usage of hydrocollator. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/30/15.	**4/30/15**

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A follow-up face-to-face interview was conducted with Employees #3 and 4 on April 20, 2015 at approximately 2:30 PM regarding the training for hot pack application. Employee #4 stated that all [four (4)] Restorative Aides apply the hot packs but one (1) of them did not have classroom training by the in-service Director. Employee #13 was trained by an " experienced " Restorative Aide.

The records were reviewed on April 20, 2015.

F 334 SS=E

483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS

The facility must develop policies and procedures that ensure that --
(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the

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F 334	Continued From page 17 influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	1. All residents who were found deficient were not reported or observed to have been harmed by this deficient practice. 2. All residents who were found deficient based on the facility's Pneumococcal Vaccine Policy dated December 2011 will be offered and given once consents are given by resident and/or family. 3. *a)* Pneumococcal Vaccine Policy and Procedure will be updated according to the ACIP (Advisory Committee on Immunization Practices)/CDC/ACP (American Colleges of Physicians) recommendations. *b)* All newly admitted residents to the facility will be offered Pneumococcal vaccine if no history given/noted, unless contraindicated. Immunization line listing is created to monitor and track down all residents who received initial Pneumococcal vaccination and those who will need a revaccination in a timely manner. 4. DON/ADON or designee will monitor Immunization line listing weekly and randomly. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action will be completed by 5/31/15.	5/31/15

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This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for 18 of 35 sampled residents, it was determined that facility staff failed to ensure that the immunization program included a method to assess the need, validate a reason, and offer a second pneumococcal immunization [re-vaccination] for eligible residents. Residents ' #6, 7, 8, 9, 10, 11, 13, 16, 17, 18, 19, 20, 22, 23, 24, 30, 34, and 41.

The findings include:

A review of the facility ' s Pneumococcal Vaccine Policy dated December 2011 stipulates: "Residents may be encouraged to receive a second pneumococcal immunization after five years based on an assessment and practitioner recommendation unless medically contraindicated or refused by the resident or their legal representative."

A review of clinical records revealed the following residents were over the age of 65 years old and received the pneumococcal vaccination greater than five (5) years ago. There was no evidence that the residents were offered a second pneumococcal vaccination [Resident identifier followed by date of most recent pneumococcal vaccine]:

Resident #6 last received the pneumococcal vaccine on March 22, 2009; Resident #7, on December 1, 2005; Resident #8, on December 15, 2003; Resident #9, on January 1, 2000; Resident # 10, on March 1, 2002; Resident #11, on October 25, 2005; Resident #13, on October 1, 2004; Resident #16, on April 11, 2007;

F 334 Continued From page 19

Resident #17, on November 1, 2001; Resident #18, on November 20, 2007; Resident #19, on March 28, 2007; Resident # 20, on December 1, 2006; Resident #22, on September 4, 2009; Resident #23, on November 1, 1999; Resident #24, on November 19, 2007; Resident #30, on October 1, 2005; Resident #34, on April 9, 2008 and Resident #41 ' s last pneumococcal vaccine was administered October 31, 2004.

There was no evidence that facility staff implemented a protocol for tracking pneumococcal re-vaccination status to determine the need for and/or offering of the vaccine.

A face-to-face interview was conducted on April 20, 2015 at approximately 3:00 PM with Employee # 3. He/she acknowledged the findings. The records were reviewed on April 20, 2015.

F 371 SS=E

483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

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

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, it was determined that facility staff failed to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 20 consistently monitor food temperatures on the steam table prior to distribution as a method to prevent food borne illness. The findings include: On April 17, 2015 at approximately 8:30 AM, the food service staff was observed serving breakfast to residents in the dining area located on the 1st floor. Upon review of the " Tray Line Taste & [and] Temperature Log, " it was noted the food service staff failed to consistently monitor food temperatures prior to plating and serving food. The " Tray Line Taste & Temperature Log " was used to record food temperatures. The documentation recorded in the " 3rd Temperatures " column of the log was representative of the steam table temperature prior to plating food. A review of Tray Line Taste & Temperature Log sheets for the period of January through April revealed that food service staff failed to monitor temperatures at the point of tray line distribution as follows: January 1-31, 2015- No temperatures documented for any meal (breakfast, lunch or dinner) February 1-28, 2015 - No temperatures documented for any meal March 1-31, 2015 - No temperatures documented for any meal April 1, 2015 - No temperatures documented for breakfast and lunch	F 371	1. There was no resident who was observed and reported to have been affected by this deficient practice. 2. An in-service was given on 4/21/15 to all dietary staff on the importance of monitoring food temperatures prior to plating and serving food. In-service also included proper procedures for food temperature documentation. 3. Food Production Manager, Food Service Manager or designee will perform daily food temperature check using the revised Manager's Temperature Log *(See Appendix 2)* to ensure accuracy and proper documentation. 4. Temperature records will be reviewed on a weekly basis during food production meetings. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action has been completed on 4/22/15.	**4/22/15**

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April 2, 2015 - No temperature documented for Supper

April 3, 2015 - No temperatures documented for Breakfast and Lunch

April 12, 2015 - No temperatures documented for any meal

April 13, 2015 - No temperatures documented for Breakfast and Lunch

April 16, 2015 - No temperatures documented for Supper

A face-to-face interview was conducted with Employees' #10 and #11 on April 17, 2015 at approximately 9:20 AM. After reviewing the temperature log book, Employee #11 stated that normal procedure was to record the temperatures of the food daily prior to distribution from the steam table. The temperature is recorded on the temperature log under the " 3rd temperature(s) " entry. Employee #10 acknowledged that the temperatures were not consistently monitored prior to distribution from the steam table.

F 441 SS=E

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control

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F 441	Continued From page 22 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interview for two (2) of 35 sampled residents, it was determined that facility staff failed to ensure that the infection control program consistently demonstrated practices to reduce the spread of infection as evidenced by a failure to include surveillance [track & trend] of all residents affected by a respiratory/flu-like illness. Residents	F 441	A. 1. Residents #35 and #39 were not reported or observed to have been harmed by this deficient practice and they were added to the infection line listing. 2. A review of all residents' records who presented a respiratory or flu like illness was done and no other residents were affected by this deficient practice. 3. All residents who will present a respiratory symptoms or flu like illness regardless of the use of antibiotics will be included in the Infection Tracking and Trending Log/report. 4. DON/ADON or designee will monitor the Infection Tracking and Trending Log results weekly. All findings will be reported to the monthly Infection meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/30/15.	4/30/15

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JEANNE JUGAN RESIDENCE	4200 HAREWOOD ROAD NE WASHINGTON, DC 20017

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F 441	Continued From page 23 # 35 and 39. The findings include: A review of the facility's January 2015 "Infection Control Log" revealed ten (10) residents were listed; two (2) of the 10 residents had nosocomial skin infections and eight (8) of the 10 residents were being treated for respiratory type concerns. Subsequent to the surveyor ' s inquiry, facility staff contacted their pharmacy provider and obtained a " Tamiflu Report" that revealed Residents' #35 (January 5, 2015) and #39 (January 16, 2015) were prescribed Tamiflu [a medication] for treatment of flu-like illness. It was determined there was no evidence that facility staff included Residents # 35 and #39 in the Infection Control surveillance. A face-to-face interview was conducted on April 20, 2015 at approximately 3:00 PM with Employee # 3. He/she stated, "The facility only tracked residents that received antibiotic treatment and not those treated with Tamiflu. B. Based on observation and staff interview, it was determined that facility staff failed to practice proper hand hygiene while plating food during the lunch meal service in one (1) of two lunch meals observed. The findings include: A dining observation was conducted on April 17, 2015 at approximately 12:05 PM - 12:25 PM. Employee #10 was observed wearing clear	F 441	B. 1. There was no resident who was reported or observed to have been affected by this deficient practice. 2. An in-service was given on 4/21/15 on "Usage of Gloves" to all dietary staff specifically stating; *"remove gloves before answering a phone of any type, wash hands and re-glove with a new pair (see appendix 1).* Another Infection in-service was given on 4/22/15 on the "Proper Hand Hygiene while plating food during meals". *(See appendix 2)* 3. Infection Control Meal Checklist was revised and will be utilized to monitor compliance. *(see appendix 3).* 4. Dietary manager will perform rounds during meals using revised infection control meal round checklist. Beginning 4/22/15, inspections will be done every day for the first week then twice a week for the next two weeks then done monthly. All findings will be reported to monthly infection meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/22/15	4/22/15

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	09E020	A. BUILDING ______ B. WING ______	04/20/2015

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F 441	Continued From page 24 plastic gloves while plating lunch meals. The employee used gloved hands to answer a two-way radio/telephone that was lying on a surface proximal to the steam table at approximately 12:18 PM. The employee then proceeded to plate meals without first changing gloves. At approximately 12:24 PM, Employee #10 picked up a notebook and pen with gloved hands to record food temperatures. Subsequently, he/she proceeded to plate lunch meals with the same gloves. Employee #10 failed to utilize proper hand hygiene practices while distributing food. He/she acknowledged the findings at the completion of the lunch meal.			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced			

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F 514	Continued From page 25 by: Based on record review and staff interview for one (1) of 35 sampled residents, it was determined that facility staff failed to consistently document fluid intake for one (1) resident that was prescribed fluid restriction for the management of the diagnosis end stage renal disease. Resident #18. The findings include: A review of Resident #18 ' s clinical record revealed his/her diagnoses included Pulmonary Edema, Volume Overload and End Stage Renal Disease on Hemodialysis. A review of physician's orders signed and dated April 16, 2015 directed, "Diet Orders: Fluid Restriction 1500 ml; 11-7= 100ml, 7-3= 400ml, 3-11 = 600ml (order originated February 27, 2015). A review of the " Intake and Output Chart " flow sheets for the months of March 2015 and April 2015 revealed Resident #18 ' s oral intake ranged from 900 cc to 1100 ml of fluid every 24 hours. A face-to-face interview with Employee #12 was conducted on April 17, 2015 at approximately 1:00 PM. He/she stated that the resident consumes more fluids than 900-1100 ml daily, however; 300 - 400 ml are set aside to account for ' miscellaneous ' intake (hydration consumed during participation in activities etc.) and is not recorded; " we make sure [he/she] does not exceed the restricted limit and the resident is very aware of [his/her] limits also. " A dietary note dated April 17, 2015 at 17:47 (5:47	F 514	1. Resident #18 was not observed or reported to have been harmed by this deficient practice. 2. All other residents with fluid restriction orders were reviewed and the facility is found to be in compliance. 3. Fluid restriction order of Resident #18 was clarified with Primary Physician in collaboration with the dietician to reflect the accurate breakdown of the fluids within a 24 hour period to equal 1500ml/daily. An In-service was given to licensed staffs on the accurate breakdown of 1500ml/daily fluid restriction of resident #18 on 4/20/15. 4. Monthly “Intake and Output Chart” will be checked and monitored by DON/ADON or designee. All findings will be reported to the Department Head monthly meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/20/15.	**4/20/15**

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F 514 Continued From page 26

PM) revealed; " Resident ' s current documented intake of fluids ranging 900 cc - 1100 cc does not reflect [his/her] miscellaneous consumption. Resident ' s fluid distribution for all shifts reflecting the 1500 cc restriction will be clarified as follows: 7-3 shift will be 800cc, 3-11 shift will 600cc, and 11-7 shift will be 100cc. The 7-3 and 3-11 shift fluid intake will be obtained from meals, med pass, HS (hour of sleep), and mid-day Glucerna supplement. The 11-7 shift will reflect resident ' s miscellaneous intake... "

The clinical record lacked evidence that facility staff consistently maintained a record of Resident #18 ' s 'miscellaneous' fluid intake.

A face-to-face interview was conducted with Employee #9 on April 17, 2015 at approximately 1:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on April 17, 2015.

F 520 SS=D

483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

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F 520	Continued From page 27 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) committee failed to develop, implement, and/or revise appropriate corrective actions for identified deficient practices. The findings include: During the recertification survey, the following areas of concern were identified: 483.25 (n) F-334 Influenza and Pneumococcal Immunizations; 483.65 F-441 Infection Control On April 20, 2015 at approximately 3:00 PM, a face-to-face interview was conducted with Employee # 3 regarding their QAA Committee Meetings and identification of the concerns listed	F 520	1. All residents who were found deficient were not reported or observed to have been harmed by this deficient practice. 2. All residents who were found deficient based on the facility's Pneumococcal Vaccine Policy dated December 2011 will be offered and given once consents are given by resident and/or family. 3. *a)* Pneumococcal Vaccine Policy and Procedure will be updated according to the ACIP (Advisory Committee on Immunization Practices)/CDC/ACP (American Colleges of Physicians) recommendations. *b)* All newly admitted residents to the facility will be offered Pneumococcal vaccine if no history given/noted, unless contraindicated. Immunization line listing is created to monitor and track down all residents who received initial Pneumococcal vaccination and those who will need a revaccination in a timely manner. 4. DON/ADON or designee will monitor Immunization line listing weekly and randomly. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action will be completed by 5/31/15.	**5/31/15**

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F 520	Continued From page 28 above. Employee #3 stated that the committee met in January 2015. However, there was no evidence that the Quality Assurance Committee developed corrective measures to address the identified issue and to address the subsequent concerns related to the facility assessing the need, to offer residents who are age 65 and over a second pneumococcal immunization [re-vaccination] as per the facility policy. In addition, the facility failed to track all residents affected by respiratory illness.			

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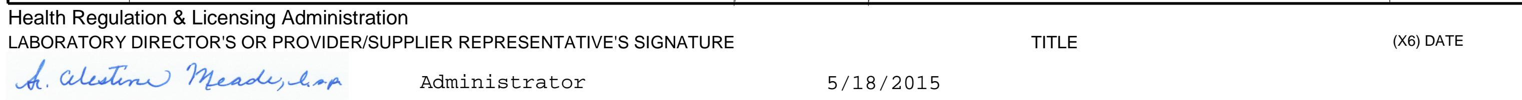
L 000	Initial Comments	L 000		

A Licensure Survey was conducted April 13 through 20, 2015. The deficiencies are based on observation, record review, resident and staff interviews for 35 sampled residents.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE


Administrator 5/18/2015

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L 000	Continued From page 1 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview for 18 of 35 sampled residents, it was determined that facility staff failed to ensure that the immunization program included a method to assess the need, validate a reason, and offer a second pneumococcal immunization [re-vaccination] for eligible residents. Residents ' #6, 7, 8, 9, 10, 11, 13, 16, 17, 18, 19, 20, 22, 23, 24, 30, 34, and 41.	L 001	1. Resident #39 was not observed or reported to have been harmed by this deficient practice. An in service was given on 4/17/15 to Employee #7 on promoting privacy and confidentiality when a medical treatment is performed. 2. No other resident is affected by this deficient practice. 3. An in service was given to all license nurses on 4/21/15 until 4/30/15 on Promoting Privacy and Confidentiality for all residents anytime a medical treatment is provided or performed. A Resident's rights in- service is given annually to all staff by SW. 4. DON/ADON or designee will do a random check and observation weekly on licensed staff on different shifts. All findings will be reported to the Monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/30/15.	4/30/15

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L 001	Continued From page 2 The findings include: According to Title 22B DCMR 3222.2, " Influenza and pneumococcal immunization shall be provided and updated in accordance with the lasts recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention ... " A review of the facility ' s Pneumococcal Vaccine Policy dated December 2011 stipulates: "Residents may be encouraged to receive a second pneumococcal immunization after five years based on an assessment and practitioner recommendation unless medically contraindicated or refused by the resident or their legal representative." A review of clinical records revealed the following residents were over the age of 65 years old and received the pneumococcal vaccination greater than five (5) years ago. There was no evidence that the residents were offered a second pneumococcal vaccination [Resident identifier followed by date of most recent pneumococcal vaccine]: Resident #6 last received the pneumococcal vaccine on March 22, 2009; Resident #7, on December 1, 2005; Resident #8, on December 15, 2003; Resident #9, on January 1, 2000; Resident # 10, on March 1, 2002; Resident #11, on October 25, 2005; Resident #13, on October 1, 2004; Resident #16, on April 11, 2007; Resident #17, on November 1, 2001; Resident	L 001	1. All residents who were found deficient were not reported or observed to have been harmed by this deficient practice. 2. All residents who were found deficient based on the facility's Pneumococcal Vaccine Policy dated December 2011 will be offered and given once consents are given by resident and/or family. 3. *a)* Pneumococcal Vaccine Policy and Procedure will be updated according to the ACIP (Advisory Committee on Immunization Practices)/CDC/ACP (American Colleges of Physicians) recommendations. *b)* All newly admitted residents to the facility will be offered Pneumococcal vaccine if no history given/noted, unless contraindicated. Immunization line listing is created to monitor and track down all residents who received initial Pneumococcal vaccination and those who will need a revaccination in a timely manner. 4. DON/ADON or designee will monitor Immunization line listing weekly and randomly. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action will be completed by 5/31/15.	5/31/15

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L 001	Continued From page 3 #18, on November 20, 2007; Resident #19, on March 28, 2007; Resident # 20, on December 1, 2006; Resident #22, on September 4, 2009; Resident #23, on November 1, 1999; Resident #24, on November 19, 2007; Resident #30, on October 1, 2005; Resident #34, on April 9, 2008 and Resident #41 ' s last pneumococcal vaccine was administered October 31, 2004. There was no evidence that facility staff implemented a protocol for tracking pneumococcal re-vaccination status to determine the need for and/or offering of the vaccine. A face-to-face interview was conducted on April 20, 2015 at approximately 3:00 PM with Employee # 3. He/she acknowledged the findings. The records were reviewed on April 20, 2015.	L 001		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for	L 051		

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L 051	Continued From page 4 direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview for two (2) of 35 sampled residents, it was determined that the charge nurse failed to initiate care plans with goals and approaches to address two (2) residents ' medication allergies. Residents ' #18 and #36. The findings include: 1. The charge nurse failed to address Resident #18 ' s medication allergy history to Ace Inhibitors (drug used primarily for the treatment of hypertension), Angiotensin Receptor Blockers (drugs used for controlling high blood pressure, treating heart failure and preventing kidney failure) and NSAIDS (Non-steroidal Anti-Inflammatory Drugs - analgesic medication that reduces pain, fever and inflammation). The " Physician ' s Order " signed and dated February 12, 2015 revealed, " Allergies: Ace Inhibitors, Angiotensin Receptor Blockers and NSAIDS " A review of the clinical record for Resident #18 lacked evidence that a care plan was initiated with goals and approaches to address the specific history of medication allergies to Ace Inhibitors, Angiotensin Receptor Blockers and NSAIDS.	L 051	FINDING # 1 1. Resident #18 was not reported or observed to have been harmed by this deficient practice. Allergy care plan with goals and interventions was added to reflect resident's allergy to Ace Inhibitors, Angiotensin Receptor blockers, and NSAIDS on 4/17/15. 2. An audit was done on all residents' care plans with allergies by MDS Coordinator which was completed on 4/23/15. Residents who were found deficient were not reported or observed to have been harmed by this practice. 3. MDS Coordinator was in-serviced on 4/23/15 on care planning allergies for all residents. 4. A weekly and random check or audit of care plans will be done by DON/ADON or designee. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 4/23/15.	4/23/15

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L 051	Continued From page 5 A face-to-face interview was conducted with Employee #3 on April 17, 2015 at approximately 11:30 AM. He/she acknowledged that there was no care plan in place to address the resident 's allergies. The record was reviewed on April 17, 2015. 2. The charge nurse failed to initiate a care plan with goals and approaches to address the Resident #36 ' s allergy to Penicillin (antibiotic). A review of the history and physical examination signed and dated May 29, 2014, revealed: "Allergies: Penicillin." The MAR (Medication Administration Records) dated January through April 2015 revealed; " Allergies: Penicillin. " A review of the clinical record for Resident #36 lacked evidence that a care plan was initiated with goals and approaches to address the specific medication allergy to Penicillin. A face-to-face interview was conducted with Employee #3 on April 17, 2015 at approximately 11:30 AM. He/she acknowledged that there was no care plan in place to address the resident 's medication allergy history. The record was reviewed on April 17, 2015.	L 051	FINDING # 2 1. Resident #36 was not reported or observed to have been harmed by this deficient practice. Allergy care plan with goals and interventions was added to reflect resident's allergy to Penicillin on 4/17/15. 2. An audit was done on all residents' care plans with allergies by MDS Coordinator which was completed on 4/23/15. 3. Residents who were found deficient were not reported or observed to have been harmed by this practice. MDS Coordinator was in-serviced on 4/23/15 on care planning allergies for all residents. 4. A weekly and random check or audit of care plans will be done by DON/ADON or designee. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 4/23/15.	**4/23/15**
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and	L 052		

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L 052	Continued From page 6 rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help.	L 052		

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	HFD02-0016	A. BUILDING: ______ B. WING ______	04/20/2015

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L 052	Continued From page 7 This Statute is not met as evidenced by: A. Based on observation and staff interview for one (1) of 35 sampled residents, it was determined that sufficient nursing time was given to each resident to promote privacy for Resident #39 as evidenced by a licensed nurse observed performing a blood glucose assessment in the common room in the presence of five (5) other residents and two (2) visitors. The findings include: On April 17, 2015 at approximately 4:00 PM Employee # 7 was observed in the Good Shepherd dayroom obtaining blood from Resident # 39's finger. After Employee #7 performed the blood glucose test he/she then verbalized the test results to the resident. At the time of the observation, five (5) residents and two (2) visitors were present in the dayroom. A face-to-face interview was conducted with Employee # 7 at the time of the observation. He/she acknowledged the findings. There was no evidence that facility staff provided privacy to Resident #39 when performing a blood glucose assessment. B. Based on record review and staff interview for three (3) of 35 sampled residents, it was determined that sufficient nursing time was given to each resident to accurately code the minimum data set (MDS) for: one (1) resident with a diagnosis of schizoaffective disorder, one (1) resident with a diagnosis of vascular dementia, and one (1) resident with diagnoses of Alzheimer	L 052	FINDING A. 1. Resident #39 was not observed or reported to have been harmed by this deficient practice. An in service was given on 4/17/15 to Employee #7 on promoting privacy and confidentiality when a medical treatment is performed. 2. No other resident is affected by this deficient practice. 3. An in service was given to all license nurses on 4/21/15 until 4/30/15 on Promoting Privacy and Confidentiality for all residents anytime a medical treatment is provided or performed. A Resident's rights in- service is given annually to all staff by SW. 4. DON/ADON or designee will do a random check and observation weekly on licensed staff on different shifts. All findings will be reported to the Monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/30/15.	4/30/15

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L 052	Continued From page 8 ' s Disease, Depression and Anxiety Disorder. Residents' #16, 39 and 41. The findings include: 1. Facility staff failed to ensure that sufficient nursing time was given to accurately code Section I [Active Diagnosis] of the annual MDS for vascular dementia for Resident #16. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of December 8, 2014 revealed that under Section I the resident was coded as having Alzheimer's disease. According to a " Medical Examination " dated April 17, 2014 Resident # 16 ' s active problems included: Dementia with Agitation and Depression. A " Psychiatric Evaluation " dated September 12, 2014 revealed that the resident was on the following psychotropic medications: Aricept 10 mg every hour of sleep for memory loss, Remeron 7.5mg every hour of sleep for Depression... Psychiatric Diagnosis: Vascular Dementia with Depression. " There was no evidence that facility staff coded the resident for vascular dementia on the annual MDS. A face-to-face interview was conducted with Employee #5 on April 20, 2015 at approximately 12:00 PM regarding the aforementioned finding. He/she acknowledged the annual MDS was not coded to reflect the resident ' s diagnosis of vascular dementia. The clinical record was reviewed on April 20, 2015.	L 052	FINDING B1. 1. Resident #16 was not observed or reported to have been harmed by this deficient practice. Annual Minimum Data Set was modified on 4/22/15 and Vascular Dementia was added to Section I. 2. An audit was done on all Section I of residents with completed MDS. Residents who were found deficient were not reported or observed to have been harmed by this practice. Employee #5(MDS Coordinator) reviewed the RAI manual on coding Section I on 4/22/15. 3. MDS Coordinator will review all residents' consultation forms and list of diagnosis thoroughly and code section I accurately based on the RAI manual before submitting completed MDS. 4. A random and monthly audit will be done by DON/ADON or designee to ensure compliance. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 4/22/15.	**4/22/15**

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L 052	Continued From page 9 2. Facility staff failed to ensure that sufficient nursing time was given to accurately code Section I [Active Diagnosis] of the quarterly MDS for Resident #39 with a diagnosis of schizoaffective disorder. The physician ' s order dated January 19, 2015 directed, "Abilify 5 mg take one (1) tablet by mouth at bedtime for schizo-effective disorder." A review of the psychiatric consultation dated November 14, 2014 revealed that Resident #39 ' s diagnoses included " schizoaffective disorder, depressed type. " A review of the quarterly MDS completed January 23, 2015 revealed that the resident's diagnosis of schizoaffective disorder of the depressed type was not coded under Section I. A face-to-face interview was conducted with Employee #5 on April 17, 2015 at approximately 12:50 PM. He/she acknowledged the findings. The record was reviewed on April 17, 2015. 3. Facility staff failed to ensure that sufficient nursing time was given to code Section I, Active Diagnosis, of the quarterly MDS for Depression and Psychosis for Resident #41. 3A. A review of the quarterly MDS dated March 12, 2015 for Resident #41, lacked evidence of coding for the active diagnosis of Depression. Physician ' s orders dated December 31, 2014 directed, " Increase Remeron 15mg po qhs [by mouth at hour of sleep for] depression."	L 052	FINDING B2 1. Resident #39 was not reported or observed to have been harmed by this deficient practice. Quarterly MDS was modified and submitted on 4/17/15 and Schizoaffective Diagnosis was added to Section I. 2. All residents' completed and submitted MDS were reviewed and audited by MDS Coordinator focusing on Section I. Residents who were found deficient were not reported or observed to have been harmed by this deficient practice. Employee #5(MDS Coordinator) reviewed the RAI manual on coding Section I on 4/17/15. 3. MDS Coordinator will review all residents' consultation forms and list of diagnosis thoroughly and code section I accurately based on the RAI manual before submitting completed MDS. 4. A random and monthly audit will be done by DON/ADON or designee to ensure compliance. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 4/17/15.	4/17/15

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L 052	Continued From page 10 A review of the Psychiatric Evaluation record dated October 23, 2014 revealed, " FU [follow up] psych eval [evaluation]. The patient is 87 yo [years old] ... with a hx of dementia with depression ... " A review of the Psychiatric Evaluation dated March 18, 2015 revealed a Psychiatric Hx [history] that noted, " This is a follow up psych evaluation. ... with a hx of dementia ... psychiatric diagnosis was Dementia with depression ... " A review of the quarterly MDS signed March 12, 2015 revealed that Depression was not coded under section I. A face-to-face interview was conducted on April 20, 2015 at approximately 10:30AM with Employee # 5. After reviewing the MDS he/she acknowledged the findings and stated that a correction would be made. The record was reviewed on April 20, 2015. 3B.The quarterly MDS dated March 12, 2015 lacked evidence of coding for the active diagnosis of Psychosis for Resident #41. A review of the psychiatric evaluation dated March 18, 2015 revealed, " Psychotropic Medications ...Risperdal 1MG [milligram] PO QD [everyday] ...Indication - psychosis ... " A review of the quarterly MDS completed March 12, 2015 revealed that under Section I , the diagnosis of Psychosis was not coded.. A face-to-face interview was conducted on April 20, 2015 at approximately 10:30AM with Employee # 5. After reviewing the MDS he/she	L 052	FINDING B3 1. Resident # 41 was not reported or observed to have been harmed by this deficient practice. Quarterly MDS was modified and submitted on 4/17/15. Depression and Psychosis were added to Section I. 2. All residents' completed and submitted MDS were reviewed and audited by MDS Coordinator focusing on Section I. Residents who were found deficient were not reported or observed to have been harmed by this deficient practice. Employee #5(MDS Coordinator) reviewed the RAI manual on coding Section I on 4/17/15. 3. MDS Coordinator will review all residents' consultation forms and list of diagnosis thoroughly and code section I accurately based on the RAI manual before submitting completed MDS. 4. A random and monthly audit will be done by DON/ADON or designee to ensure compliance. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action was completed on 4/17/15.	4/17/15

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L 052	Continued From page 11 acknowledged the findings and stated that a correction would be made. The record was reviewed on April 20, 2015. C. Based on record review and staff interview for two (2) of 35 sampled residents, it was determined that sufficient nursing time was given to each resident: to clarify orders for fluid restrictions for one (1) resident with End Stage Renal Disease; and to administer Psychotropic medication to one (1) resident, as directed by the physician. Residents ' #18 and 31. The findings include: 1.Facility staff failed to ensure that sufficient nursing time was given to clarify an order for fluid restriction for Resident #18 who has a diagnosis of End Stage Renal Disease. A review of the medical record revealed that Resident #18 was readmitted to the facility on February 27, 2015 with diagnoses that included: Pulmonary Edema, Volume Overload and End Stage Renal Disease. A review of physician's orders signed and dated April 16, 2015 directed, "Diet Orders: Fluid Restriction 1500 ml; 11-7= 100ml, 7-3= 400ml, 3-11 = 600ml [order originated February 27, 2015]. Although the fluid restriction order stipulates 1500 ml ' s, the breakdown of fluid of amounts over a 24 hour period [11-7, 7-3, 3-11] equaled 1100ml ' s. A Review of the Medication Administration	L 052	FINDING C1. 1. Resident #18 was not observed or reported to have been harmed by this deficient practice. 2. All other residents with fluid restriction orders were reviewed and the facility is found to be in compliance. 3. Fluid restriction order of Resident #18 was clarified with Primary Physician in collaboration with the dietician to reflect the accurate breakdown of the fluids within a 24 hour period to equal 1500ml/daily. An In-service was given to licensed staffs on the accurate breakdown of 1500ml/daily fluid restriction of resident #18 on 4/20/15. 4. Monthly “Intake and Output Chart” will be checked and monitored by DON/ADON or designee. All findings will be reported to the Department Head monthly meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/20/15.	4/20/15

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L 052	Continued From page 12	L 052		

Record [MAR] for February 2015 revealed the resident received the following: " Fluid Restrictions 1500 ml daily- 11-7 = 100, 7-3=400ml, 3-11 = 500ml as evidenced by the nurses' initials in the allotted spaces. However, the amount allotted for each shift totaled 1000 ml for every 24 hours.

A review of the " Intake and Output Chart " flow sheets for the months of March 2015 and April 2015 revealed that Resident #18 had an oral intake ranging from 900ml to 1100 ml of fluid every 24 hours.

A review of the medical record lacked evidenced that the physician's order was clarified to verify the amount of fluid Resident #18 was to receive in a 24-hour period.

A face-to-face interview was conducted with Employees #2 and 9 on April 20, 2015 at approximately 1:00 PM. After reviewing the clinical record, both acknowledged the aforementioned finding. The clinical record was reviewed on April 20, 2015.

2. Facility staff failed to ensure that sufficient nursing time was given to administer Resident #31' s psychotropic medication, as directed by the physician.

Physician's orders dated October 24, 2014 directed, " Escitalopram [Lexapro] tab [tablet] 20 mg [milligrams], take one tablet by mouth every morning for Anxiety."

A review of the March 2015 Medication Administration Record [MAR] revealed that on March 22, 2015 at 8:00AM, the space allotted to indicate that the Lexapro was administered was

Provider's Plan of Correction:

FINDING C2.

1. Resident # 31 was not reported or observed to have been harmed by this deficient practice.
2. All Medication Administration Records of residents who are receiving psychotropic medications were reviewed and the facility is found to have been compliant. Deficient employee was in serviced on the Policy and procedure on Medication Administration on 4/20/15.
3. An in-service on the Policy and Procedure of Medication Administration was completed on 4/30/15 to all nursing licensed staff. An in service on the Policy and Procedure on Medication Administration will be given to all new Licensed Nursing staff during orientation and annually.
4. A monthly random check and audit of the Medication Administration Record will be done by DON/ADON or designee. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings.
5. Corrective action was completed on 4/30/15.

Complete date: **4/30/15**

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L 052	Continued From page 13 left blank [indicating that the medication was not given]. There was no evidence that on March 22, 2015 at 8:00AM, the facility staff administered Lexapro to Resident #31, as ordered by the physician. A face-to-face interview was conducted on April 20, 2015 at approximately 10:30 AM with Employee # 3 regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on April 20, 2015. D. Based on record review and staff interview for one (1) of 35 sampled residents, it was determined that sufficient nursing time was given to each resident to consistently document fluid intake for one (1) resident that was prescribed fluid restriction for the management of the diagnosis end stage renal disease. Resident #18. The findings include: A review of Resident #18 ' s clinical record revealed his/her diagnoses included Pulmonary Edema, Volume Overload and End Stage Renal Disease on Hemodialysis. A review of physician's orders signed and dated April 16, 2015 directed, "Diet Orders: Fluid Restriction 1500 ml; 11-7= 100ml, 7-3= 400ml, 3-11 = 600ml (order originated February 27, 2015). A review of the " Intake and Output Chart " flow sheets for the months of March 2015 and April 2015 revealed Resident #18 ' s oral intake ranged	L 052	FINDING D. 1. Resident #18 was not observed or reported to have been harmed by this deficient practice. 2. All other residents with fluid restriction orders were reviewed and the facility is found to be in compliance. 3. Fluid restriction order of Resident #18 was clarified with Primary Physician in collaboration with the dietician to reflect the accurate breakdown of the fluids within a 24 hour period to equal 1500ml/daily. An In-service was given to licensed staffs on the accurate breakdown of Resident #18's 1500ml/daily fluid restriction and accurate documentation on 4/20/15. 4. Daily "Intake and Output Chart" will be checked and monitored monthly and randomly by DON/ADON or designee. All findings will be reported to the Department Head monthly meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/20/15.	4/20/15

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L 052	Continued From page 14	L 052		

from 900 cc to 1100 ml of fluid every 24 hours.

A face-to-face interview with Employee #12 was conducted on April 17, 2015 at approximately 1:00 PM. He/she stated that the resident consumes more fluids than 900-1100 ml daily, however; 300 - 400 ml are set aside to account for ' miscellaneous ' intake (hydration consumed during participation in activities etc.) and is not recorded; " we make sure [he/she] does not exceed the restricted limit and the resident is very aware of [his/her] limits also. "

A dietary note dated April 17, 2015 at 17:47 (5:47 PM) revealed; " Resident ' s current documented intake of fluids ranging 900 cc - 1100 cc does not reflect [his/her] miscellaneous consumption. Resident ' s fluid distribution for all shifts reflecting the 1500 cc restriction will be clarified as follows: 7-3 shift will be 800cc, 3-11 shift will 600cc, and 11-7 shift will be 100cc. The 7-3 and 3-11 shift fluid intake will be obtained from meals, med pass, HS (hour of sleep), and mid-day Glucerna supplement. The 11-7 shift will reflect resident ' s miscellaneous intake... "

The clinical record lacked evidence that facility staff consistently maintained a record of Resident #18 ' s 'miscellaneous' fluid intake.

A face-to-face interview was conducted with Employee #9 on April 17, 2015 at approximately 1:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on April 17, 2015.

E. Based on observation, record review and staff interview, it was determined that sufficient nursing time was given to each resident to ensure

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L 052	Continued From page 15 residents' were free of potential accident hazards, as evidenced by the application of hydrocollator packs [moist heat] by one (1) of four (4) staff persons [Restorative Aides] that was not trained in the use of moist heat therapy. The findings include: According to the facility's " Restorative Nursing " policy dated December 2010, "The Director of Nursing has overall responsibility for the restorative nursing care program in accordance with nursing policies and procedures. (a). The Department Head is responsible for monitoring the nursing staff in carrying out the program. (b). The in-service Director is responsible for training all nursing staff in restorative nursing techniques by providing group classes and/or one-on-one teaching sessions ... " During an environmental tour of the Rehabilitation Department with Employee #6 on April 20, 2015 at approximately 10:00 AM, Two (2) hydrocollator machines were in use. A " Hot Pack Treatment Chart " was observed on a ledge, proximal to the hydrocollator machine. A query was made to Employee #8 regarding whether or not any residents were receiving heat therapy and if so, who was responsible for administering the treatment? Employee # 8 stated, "Yes, " the residents listed on the Hot Pack Treatment Chart were receiving heat therapy and the Restorative Aides were trained to apply the hot packs. Through face-to-face interview with Employee #4 on April 20, 2015 at approximately 2:00 PM, it was determined that four (4) Restorative Aides had duties that included the application of heat therapy via " Hot Packs. "	L 052	FINDING E. 1. Residents who received hydrocollator packs/hot packs have not been reported or observed to have been harmed by this deficient practice. 2. An in-service was given to employee #13 on Hydrocollator Usage on 4/30/15. 3. *a).* All new restorative nurses and restorative aides will be given an in-service and training on Hydrocollator usage before they are allowed to use hot packs/hydrocollator packs. *b).* A skill competency checklist for restorative aides or restorative nurses will be utilized and checked off upon employment and annually. 4. DON/ADON or designee will do a monthly and random check on accurate usage of hydrocollator. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/30/15.	**4/30/15**

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L 052	Continued From page 16 A review of clinical records revealed eleven (11) residents had physician orders for the application of hot pack treatments. The facility ' s in-service education records revealed three (3) Restorative Aides underwent training on " Hydrocollator Usage " according to training documents dated July 10, 2014. However, there was no documentation to support that Employee #13 [Restorative Aide] underwent in-service education/ training on hydrocollator usage. A follow-up face-to-face interview was conducted with Employees #3 and 4 on April 20, 2015 at approximately 2:30 PM regarding the training for hot pack application. Employee #4 stated that all [four (4)] Restorative Aides apply the hot packs but one (1) of them did not have classroom training by the in-service Director. Employee #13 was trained by an " experienced " Restorative Aide. The records were reviewed on April 20, 2015.	L 052		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: A. Based on record review and staff interview for two (2) of 35 sampled residents, it was determined that facility staff failed to ensure that the infection control program consistently demonstrated practices to reduce the spread of	L 091		

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infection as evidenced by a failure to include surveillance [track & trend] of all residents affected by a respiratory/flu-like illness. Residents # 35 and 39.

The findings include:

A review of the facility's January 2015 "Infection Control Log" revealed ten (10) residents were listed; two (2) of the 10 residents had nosocomial skin infections and eight (8) of the 10 residents were being treated for respiratory type concerns.

Subsequent to the surveyor ' s inquiry, facility staff contacted their pharmacy provider and obtained a " Tamiflu Report" that revealed Residents' #35 (January 5, 2015) and #39 (January 16, 2015) were prescribed Tamiflu [a medication] for treatment of flu-like illness.

It was determined there was no evidence that facility staff included Residents # 35 and #39 in the Infection Control surveillance.

A face-to-face interview was conducted on April 20, 2015 at approximately 3:00 PM with Employee # 3. He/she stated, "The facility only tracked residents that received antibiotic treatment and not those treated with Tamiflu.

B. Based on observation and staff interview, it was determined that facility staff failed to practice proper hand hygiene while plating food during the lunch meal service in one (1) of two lunch meals observed.

The findings include:

A dining observation was conducted on April 17,

FINDING A.

1. Residents #35 and #39 were not reported or observed to have been harmed by this deficient practice and they were added to the infection line listing.
2. A review of all residents' records who presented a respiratory or flu like illness was done and no other residents were affected by this deficient practice.
3. All residents who will present a respiratory symptoms or flu like illness regardless of the use of antibiotics will be included in the Infection Tracking and Trending Log/report.
4. DON/ADON or designee will monitor the Infection Tracking and Trending Log results weekly. All findings will be reported to the monthly Infection meetings and quarterly QAPI meetings.
5. Corrective action was completed on 4/30/15.

4/30/15

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 ______	04/20/2015

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 091	Continued From page 18 2015 at approximately 12:05 PM - 12:25 PM. Employee #10 was observed wearing clear plastic gloves while plating lunch meals. The employee used gloved hands to answer a two-way radio/telephone that was lying on a surface proximal to the steam table at approximately 12:18 PM. The employee then proceeded to plate meals without first changing gloves. At approximately 12:24 PM, Employee #10 picked up a notebook and pen with gloved hands to record food temperatures. Subsequently, he/she proceeded to plate lunch meals with the same gloves. Employee #10 failed to utilize proper hand hygiene practices while distributing food. He/she acknowledged the findings at the completion of the lunch meal.	L 091	FINDING B. 1. There was no resident who was reported or observed to have been affected by this deficient practice. 2. An in-service was given on 4/21/15 on "Usage of Gloves" to all dietary staff specifically stating; *"remove gloves before answering a phone of any type, wash hands and re-glove with a new pair (see appendix 1).* Another Infection in-service was given on 4/22/15 on the "Proper Hand Hygiene while plating food during meals". *(See appendix 2).* 3. Infection Control Meal Checklist was revised and will be utilized to monitor compliance. *(see appendix 3).* 4. Dietary manager will perform rounds during meals using revised infection control meal round checklist. Beginning 4/22/15, inspections will be done every day for the first week then twice a week for the next two weeks then done monthly. All findings will be reported to monthly infection meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/22/15	**4/22/15**
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 record review and staff interview, it was determined that facility staff failed to consistently monitor food temperatures on the steam table prior to distribution as a method to prevent food borne illness. The findings include: On April 17, 2015 at approximately 8:30 AM, the	L 099		

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L 099	Continued From page 19 food service staff was observed serving breakfast to residents in the dining area located on the 1st floor. Upon review of the " Tray Line Taste & (and) Temperature Log " , it was noted the food service staff failed to consistently monitor food temperatures prior to plating and serving food. The " Tray Line Taste & Temperature Log " was used to record food temperatures. The documentation recorded in the " 3rd Temperatures " column of the log was representative of the steam table temperature prior to plating food. A review of Tray Line Taste & Temperature Log sheets for the period of January through April revealed that food service staff failed to monitor temperatures at the point of tray line distribution as follows: January 1-31, 2015- No temperatures documented for any meal (breakfast, lunch or dinner) February 1-28, 2015 - No temperatures documented for any meal March 1-31, 2015 - No temperatures documented for any meal April 1, 2015 - No temperatures documented for breakfast and lunch April 2, 2015 - No temperature documented for Supper April 3, 2015 - No temperatures documented for Breakfast and Lunch April 12, 2015 - No temperatures documented for	L 099	1. There was no resident who was observed and reported to have been affected by this deficient practice. 2. An in-service was given on 4/21/15 to all dietary staff on the importance of monitoring food temperatures prior to plating and serving food. In-service also included proper procedures for food temperature documentation. 3. Food Production Manager, Food Service Manager or designee will perform daily food temperature check using the revised Manager's Temperature Log *(See Appendix 2)* to ensure accuracy and proper documentation. 4. Temperature records will be reviewed on a weekly basis during food production meetings. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action has been completed on 4/22/15.	**4/22/15**

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L 099	Continued From page 20 any meal April 13, 2015 - No temperatures documented for Breakfast and Lunch April 16, 2015 - No temperatures documented for Supper A face-to-face interview was conducted with Employees' #10 and #11 on April 17, 2015 at approximately 9:20 AM. After reviewing the temperature log book, Employee #11 stated that normal procedure was to record the temperatures of the food daily prior to distribution from the steam table. The temperature is recorded on the temperature log under the " 3rd temperature(s) " entry. Employee #10 acknowledged that the temperatures were not consistently monitored prior to distribution from the steam table.	L 099		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: A. Based on observations made on April 14, 2015 , it was determined that facility staff failed to ensure resident ' s environment was free of accident hazards as evidenced by a radiator heater and shredder observed in two (2) of 16 resident rooms. The findings include: 1. One [1] of [1] electric radiator heater was observed plugged into wall outlet [but not in use]	L 410	FINDING A1 1. Resident in Room # 1223 Good Shepherd Unit was not reported or observed to have been harmed by this deficient practice. 2. All residents' rooms in the facility were checked/inspected, no other electric radiator heater was found/noted and the facility is found to be in compliance. 3. a). The electric radiator heater in Room #1223 was removed immediately on 4.14.15 with the resident and family's consent. b). Upon admission into the facility, all new residents will be made aware that electric radiator heater is not permitted. 4. Maintenance department will do a monthly and random check of each resident's room for compliance. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/14/15.	**4/14/15**

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L 410	Continued From page 21 in room #1223 [Unit - Good Shepherd] on April 14, 2015 at approximately 9:30 AM. 2. One [1] of [1] electric paper shredder was observed in room 1216-1 (Unit - Good Shepherd) on April 14, 2015 at approximately 11:12 AM. These observations were made in the presence on Employee #3 who acknowledged the findings. The heater and shredder were immediately removed from the resident ' s rooms. The engineering staff stated they were unaware of the presence of the radiator heater and the shredder in the residents' rooms. B. Based on an isolated observation and staff interview it was determined that facility staff failed to post oxygen " in use " signage for Resident #15, who was receiving oxygen. The findings include: The facility policy " Portable liquid oxygen, safe storage, handling and use of " stipulates: " ...7. Fire safety (a) Post the rooms containing oxygen in use with signs stating " Oxygen in Use." A tour of the "Scared Heart" unit was conducted on April 13, 2015 at approximately 12:00 PM. Resident #15 was observed receiving, oxygen [O2] at two (2) liters [L] per minute [min] via nasal cannula [nc] continuously. There was no signage posted outside the resident's room to alert staff and visitors that oxygen was in use. A second tour of the Sacred Heart Unit was conducted on April 15, 2015 at approximately	L 410	FINDING A2 1. Resident in Room #1216-1 Good Shepherd Unit was not observed or reported to have been harmed by this deficient practice. 2. All residents' rooms in the facility were checked/inspected; no other electric paper shredder. Facility is found to be in compliance. 3. *a)* The electric paper shredder in Room 1216-1 Good Shepherd unit was inspected by the maintenance department on 4/15/15 and was removed immediately with resident's consent since appliance was not functional. *b)* Upon admission to the facility; all new residents will be made aware that all new electrical equipment/appliance (excluding electric radiator heater) will be inspected and cleared by maintenance department before initial use by the resident. *c)* Nursing care plan will be initiated 4. Maintenance Department will keep a log of each resident's electrical appliance that they have inspected and cleared. A monthly and random inspection will be made in resident's rooms to ensure compliance. All findings will be reported to the monthly Department Head meetings and quarterly QAPI meetings. 5. Corrective action was completed on 4/15/15.	**4/15/15**

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L 410	Continued From page 22 8:45 AM. At this time Resident #15 was observed receiving O2 at 2L via nasal cannula continuously. There was no signage posted outside the resident's room to alert staff and visitors that oxygen was in use. A face-to-face interview was done with Employee #2 on April 15, 2015 at approximately 12:00 PM. He/she acknowledged that the "oxygen in use" sign had previously been posted, but was no longer present. The clinical record was reviewed on April 15, 2015.	L 410	FINDING B 1. Resident #15 was not reported or observed to have been harmed by this deficient practice. Signage "Oxygen In-Use/No Smoking" was placed on Resident's door on 4/15/15. 2. All residents receiving oxygen were checked and the facility was found to be incompliance. 3. An in-service on a timely posting of Oxygen signage was given to all nursing staff on 4/21/15. 4. A weekly and random rounds of the units will be done by DON/ADON or designee to ensure compliance with the recommended plan of correction. All findings will be reported to the monthly Department Head and quarterly QAPI meetings. 5. Corrective action was completed on 4/21/15.	**4/21/15**