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 _____	05/03/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Jeanne Jugan Residence from April 29, 2016 through May 3, 2016. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 11 sampled residents during Stage 2. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1. Resident #23 was not observed or reported to have been harmed by this deficient practice. A behavior monitoring was initiated on 5/03/16 to monitor the effectiveness of the ordered anti-depressant. 2. No other resident was found or reported to have been affected and harmed by this deficient practice. An audit was performed and completed on 5/04/16 on all residents' orders to make sure that each resident receiving a routine anti-depressant has a behavior monitoring. The facility is found to be in compliance. 3. An in service was given to licensed nurses on 5/04/16 on "Initiating a Behavior Monitoring" immediately when a routine anti-depressant medication is ordered.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dr Alphonse Marie Jones	Administrator	5/12/2016

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 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 11 stage two sampled residents, it was determined that facility staff failed to adequately monitor behaviors for one (1) resident receiving an antidepressant medication [Remeron]. Resident #23. The findings include: Facility staff failed to monitor Resident #23 for signs of worsening of depression and/or the effectiveness of the medication while he/she was receiving Remeron, an antidepressant medication. A review of the Annual Minimum Data Set (MDS) dated March 5, 2016 revealed that Resident #23 ' s diagnoses included Dementia, and Depression. A review of an "Order Summary Report" signed and dated March 10, 2016 revealed a physician ' s order directing to give Resident #23 Remeron (an antidepressant) 15mg (milligrams) by mouth at bedtime for depression. A review of the Medication Administration Record (MAR) from April 2016 revealed that Resident #23 received Remeron at 8:00 PM every evening from April 1 to April 30, 2016. The clinical record lacked documented evidence that facility staff monitored Resident #23 for medication effectiveness and/or worsening signs	F 329	4. DON or ADON will perform a random and monthly audit of all residents' orders to ensure that a behavior monitoring is in place for residents receiving an anti-depressant to monitor the effectiveness of medication. All findings will be reported to the quarterly QAPI meetings. 5. Corrective action completed on 5/04/2016	5/04/16

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F 329	Continued From page 2 of depression while taking and antidepressant medication. A face-to-face interview was conducted with Employee's #3 and #11. Both employees acknowledged the aforementioned findings. The clinical record was reviewed on May 3, 2016.	F 329		
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 observation and staff interview it was determined that facility staff failed to: remove foods from storage past the expiration date, maintain food contact surfaces to prevent cross-contamination, and failed to develop a method to ensure the freezer that contained resident food was maintained in proper working order. The findings include: 1. Facility staff failed to remove expired food from the dry storage pantry. On May 2, 2016 at approximately 1:10 PM a	F 371	F 371 Finding #1: 1. There was no resident who was reported or observed to have been harmed by this deficient practice. All outdated food items were immediately removed and discarded from the dry storage pantry on 5/02/16. 2. Dietary manager performed a thorough check in the dry storage pantry on 5/04/16, no other expired items noted and the facility is found to be in compliance. 3. An in service was given to all dietary personnel on 5/04/16 to check dry storage pantry for expired food on a weekly basis. All expired or outdated dry foods will be disposed of promptly. 4. Dietary manager and QA nurse will do a random and monthly check of the dry storage pantry for expired food. All findings will be reported to the monthly safety and quarterly QAPI meeting. 5. Corrective action was completed on 5/04/2016.	5/04/2016

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F 371	Continued From page 3 kitchen tour was conducted with Employees #4 and #12. During the observation, multiple food items were observed on a metal rolling cart with three (3) shelves. The first shelf contained 14 individual bags of " Brownie Brittle, " each bag had an expiration date of October 26, 2015 marked by the manufacturer. The second shelf contained five (5) bags of Greek Yogurt Pretzel Crisps with a manufacturer's expiration date of October 8, 2015. The third shelf contained a case of " Peanut Butter Chips " with a manufacturer's expiration date of July 2015, and there were 22 bags of " Semi-Sweet Chocolate Chips " with a manufacturer's expiration date of September 2015. On May 2, 2016 at approximately 1:10 PM a face-to-face interview was conducted with Employee #4 and #12 regarding the expired foods observed in the pantry. Both acknowledged the aforementioned findings. 2. Facility staff failed to maintain food contact surfaces to prevent cross-contamination. On May 2, 2016 at approximately 1:20 PM a Kitchen observation was conducted in the presence of Employee #4 and #12. During this observation one (1) of one (1) green cutting board used to cut fruits and vegetables, was observed with three deep grooves approximately one-inch-long on the cutting surface.	F 371	F 371 Finding #2: 1. There was no resident who was reported or observed to have been affected or harmed by this deficient practice. The deficient cutting board was immediately removed and disposed of on 5/02/2016. 2. Dietary manager checked all cutting boards in the kitchen on 5/02/2016 and the facility was found to be in compliance. 3. An in service was given to all dietary personnel on 5/04/2016 to check all cutting boards for grooves and its wear and tear on a daily basis utilizing a newly created checklist form. Any cutting board that does not pass the checklist criteria will be discarded immediately. 4. Dietary Manager and QA nurse will perform monthly and quarterly checks of all the cutting boards in the kitchen. All findings will be reported to the monthly Safety and Infection meetings and quarterly QAPI meetings. 5. Corrective action completed on 5/04/2016	5/04/2016

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F 371	Continued From page 4 On May 2, 2016 at approximately 1:22 PM a face to face interview was conducted with Employees # 4, and 12. Both acknowledged the aforementioned findings. 3. Facility staff failed to develop a method to ensure the freezer that contained resident food was maintained in proper working order. On May 2, 2016 at approximately 12:35 PM a tour of the first floor resident pantry was conducted. At this time the freezer located in the pantry was observed to have no apparatus to ensure that the freezer was functioning properly. After the observation was made, a thermometer was placed in the freezer by facility staff in the presence of Employee #3. On May 3, 2016 at approximately 10:00 AM a face-to-face interview was conducted with Employee # 4. He/she explained that there was no log kept of temperatures to monitor the freezer. He/she acknowledged the aforementioned findings.	F 371	F 371 Finding #3: 1. There was no resident who was reported or observed to have been affected by this deficient practice. The existing refrigerator temperature log was revised on 5/04/2016 to include monitoring the freezer temperature. 2. The revised temperature log was immediately utilized for all freezers in the pantry area after an in service was given to the dietary personnel. 3. An in service was given to all dietary personnel on 5/04/2016 to check for freezer thermometers and temperatures for compliance and accuracy twice a day utilizing the revised temperature log. 4. Dietary manager and QA nurse will perform a random and monthly check of the freezer thermometer and thermometer log to ensure compliance. All findings will be reported to the monthly Safety meeting and quarterly QAPI meetings. 5. Corrective action was completed on 5/04/2016.	5/04/2016