| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 09E020 | A. BUILDING _____ B. WING _____ | 03/01/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Quality Indicator Survey was conducted at Jeanne Jugan Residence from February 24, 2017 through March 1, 2017. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 23 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.<br><br>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:<br><br>Abbreviations<br>AMS - Altered Mental Status<br>ARD - assessment reference date<br>BID - Twice- a-day<br>B/P - Blood Pressure<br>cm - Centimeters<br>CMS - Centers for Medicare and Medicaid Services<br>CNA- Certified Nurse Aide<br>CRF - Community Residential Facility<br>D.C. - District of Columbia<br>DCMR- District of Columbia Municipal Regulations<br>D/C Discontinue<br>Dl - deciliter<br>DMH - Department of Mental Health | F 000 | F 272<br>1. Resident #9 was not reported or observed to have been harmed by this deficient practice. Annual MDS assessment dated 11/20/16 was modified and submitted on 2/28/17 and Intellectual Disability diagnosis was added to section A1510B.<br>2. No other resident has been reported to have been affected by this deficient practice.<br>3. MDS Coordinator was in-serviced on 2/28/17 regarding accurate coding of section A using the RAI manual. MDS Coordinator will ensure that any resident with intellectual disability diagnosis will be coded accurately in section A1510B before submitting completed MDS assessment.<br>4. Random and quarterly audit of MDS section A1510B will be done by MDS coordinator to ensure compliance. DON or ADON will also monitor compliance. Any finding will be reported to the QA Committee at the quarterly meetings.<br>5. Corrective action was completed on 2/28/17. | 2/28/17 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Dr Alphonse Marie Jones | Administrator | March 22, 2017 |

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<br>EKG - 12 lead Electrocardiogram<br>EMS - Emergency Medical Services (911)<br>G-tube Gastrostomy tube<br>HSC Health Service Center<br>HVAC - Heating ventilation/Air conditioning<br>ID - Intellectual disability<br>IDT - interdisciplinary team<br>L - Liter<br>Lbs - Pounds (unit of mass)<br>MAR - Medication Administration Record<br>MD- Medical Doctor<br>MDS - Minimum Data Set<br>Mg - milligrams (metric system unit of mass)<br>mL - milliliters (metric system measure of volume)<br>mg/dl - milligrams per deciliter<br>mm/Hg - millimeters of mercury<br>MN midnight<br>Neuro - Neurological<br>NP - Nurse Practitioner<br>PASRR - Preadmission screen and Resident Review<br>Peg tube - Percutaneous Endoscopic Gastrostomy<br>PO- by mouth<br>POS - physician ' s order sheet<br>Prn - As needed<br>Pt - Patient<br>Q- Every<br>QIS - Quality Indicator Survey<br>Rp, R/P - Responsible party<br>SCC Special Care Center<br>Sol- Solution<br>TAR - Treatment Administration Record | F 000 | | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>(b) Comprehensive Assessments | F 272 | | |

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| F 272 | Continued from page 2<br><br>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br><br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the<br>care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct<br>observation and communication with the resident, as well as communication with licensed and<br>non-licensed direct care staff members on all shifts. | F 272 | | |

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| F 272 | Continued from page 3<br><br>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by:<br><br>Based on medical record review and staff interview for one (1) of 23 stage 2 sampled residents, it was determined that the facility staff failed to code the Minimum Data Set (MDS) to reflect the intellectual disability of Resident #9.<br><br>The findings include:<br><br>Review of Resident #9's, Annual MDS dated November 20, 2016 revealed that the resident was admitted to the facility on December 15, 2015 with a diagnosis of Moderate Intellectual Disability.<br><br>Under Section A1510B Intellectual Disability ("mental retardation" in federal regulation) the resident was coded as "0" which indicated the resident does not have intellectual disability/developmental disability.<br><br>However, a review of the Annual MDS dated November 20, 2016 under Section I (Active Diagnoses) revealed that the resident was coded as having Moderate Intellectual Disability.<br><br>There was no evidence that facility staff accurately coded MDS for the resident having a diagnosis of Moderate Intellectual Disability.<br><br>On February 28, 2017 at approximately 2:30 PM a face-to-face interview was conducted with | F 272 | | |

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| F 272 | Continued from page 4<br><br>Employee # 3 who acknowledged the aforementioned findings. The record was reviewed on February 28, 2017. | F 272 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | F 441 | F 441 (A)<br><br>1. No resident was observed or reported to have been affected by this deficient practice. The second step purified protein derivative (PPD) skin test was administered to Employee #8 on 3/20/17.<br><br>2. There was no other resident who has been reported or observed to have been affected or harmed by this deficient practice.<br><br>3. Facility's policy and procedure on Tuberculin Surveillance was updated on 3/17/17 to be in compliance with CDC's recommendation regarding two step tuberculin skin testing (TST) for newly hired employees.<br><br>4. Human Resource Director will assure implementation of updated Policy and Procedure on all newly hired employees effective immediately. The Human Resource QI Tool will include monitoring of newly hired employees' skin testing. Any finding will be reported to the QA Committee at the quarterly meetings.<br><br>5. Corrective action was completed on 3/21/17. | 3/21/17 |

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| F 441 | Continued from page 5<br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which 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; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for two (2) of five (5) new employees, it was determined that facility staff failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection as evidenced by failure to ensure that two (2) employees were pre-screened | F 441 | F 441 (B)<br><br>1. No resident was observed or reported to have been affected by this deficient practice. The second step purified protein derivative (PPD) skin test was administered to Employee #9 on 3/21/17.<br><br>2. There was no other resident who has been reported or observed to have been affected or harmed by this deficient practice.<br><br>3. Facility's policy and procedure on Tuberculin Surveillance was updated on 3/17/17 to be in compliance with CDC's recommendation regarding two step tuberculin skin testing (TST) for newly hired employees.<br><br>4. Human Resource Director will assure implementation of updated Policy and Procedure on all newly hired employees effective immediately. The Human Resource QI Tool will include monitoring of newly hired employees' skin testing. Any finding will be reported to the QA Committee at the quarterly meetings.<br><br>5. Corrective action was completed on 3/21/17. | 3/21/17 |

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| F 441 | Continued from page 6<br>for communicable disease prior to employment in accordance with Centers for Disease Control and the Facility's Policy. Employee #8 and #9.<br><br>The findings include:<br><br>Centers for Disease Control (CDC's) Prevention Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly Reports (MMWR) 2005:54(RR17); 1-141 stipulates:<br><br>"TB Screening Procedures ... all HCWs (health care workers) should receive baseline screening upon hire ...HCWs should receive TB screening annually (i.e., symptom screen) for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results...HCWs with a baseline positive or newly positive...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually."<br><br>"Two-step testing with the Mantoux tuberculin skin test (TST) should be used for baseline or initial testing. Some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection. " <https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm><br><br>According to the facility ' s policy "Tuberculin | F 441 | | |

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| F 441 | Continued from page 7<br>Surveillance "Employees; New employees will have a single or two step Mantoux administered by the house ..."<br><br>1. The facility failed to ensure that Employee # 8 was pre-screened for communicable disease prior to employment.<br><br>A review of Employee # 8's personnel file revealed the following:<br><br>Job Title: Certified Nursing Assistant; Date of Hire: January 24, 2017<br><br>There was no evidence in the employee's record that he/she received the two-step Purified Protein Derivative (PPD) skin test [a test that determines if you suffer from tuberculosis], a chest x-ray or the Tuberculosis Symptom Screening Questionnaire prior to or upon employment.<br><br>2. The facility failed to ensure that Employee # 9 was pre-screened for communicable disease prior to employment.<br><br>A review of Employee #8's personnel file revealed the following:<br><br>Job Title: Certified Nurse Assistant (CNA); Date of Hire: November 30, 2016<br><br>There was no evidence in the employee's record that he/she received the two-step Purified Protein | F 441 | | |

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| F 441 | Continued From page 8<br>Derivative (PPD) skin test, a chest x-ray, or the Tuberculosis Symptom Screening Questionnaire prior to or upon employment.<br><br>A face-to-face interview was conducted on March 1, 2017 with Employee #1 at approximately 1:00 PM. After review of the aforementioned he/she acknowledged the findings. The records were reviewed on March 1, 2017 | F 441 | | |
| F 456 SS=D | 483.90(c)(2)(d) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>(c)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.<br><br>(d) Resident Rooms<br>Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on February 24, 2017, at approximately 9:00 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by staff failing to leave the inside door to the prep freezer open to allow cold air to circulate throughout the whole freezer in order to maintain temperatures at freezing, and a missing slat from the air curtain located at the entrance door to the prep freezer.<br><br>The findings include:<br><br>The door located inside the prep freezer was | F 456 | F 456 (A)<br>1. There was no resident who was reported or observed to have been affected or harmed by this deficient practice.<br>2. This deficient practice was corrected immediately on 2/24/17 by keeping the door located inside the prep freezer latched open at all times. A sign was posted on the outer door of the freezer to remind staff to keep the identified door open at all times.<br>3. An in-service was given to the morning and evening dietary production staff on 3/17/17 on the importance on keeping the door located inside the prep freezer latched open at all times. The kitchen/dietary Monthly Safety Checklist will include checking and monitoring of the identified door.<br>4. Director of dietary department or designee will perform a daily check of the freezer door to ensure compliance. Quality Assurance Nurse will perform random checks. Any finding will be corrected immediately and will be reported to the Monthly Safety Meetings and to the QA Committee at the quarterly meetings.<br>5. Corrective action was completed on 3/17/17. | 3/17/17 |

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| F 456 | Continued from page 9<br>inadvertently closed, which allowed an area of the freezer to warm up to 37 degrees Fahrenheit (F).<br><br>During a face to face interview with Employee #7 on February 24, 2017 at approximately 11:30 AM, he/she explained that the inside door to the prep freezer should always be left open to ensure that temperatures are maintained at or below freezing.<br><br>On February 24, 2017 at approximately 2:00 PM, the internal temperature of the prep freezer was 17 degrees F. On February 27, 2017 at approximately 9:00 AM, the internal temperature of the prep freezer was seven (7) degrees and all items were frozen.<br><br>One (1) of five (5) slats from the air curtain located at the entrance door to the prep freezer was missing.<br><br>These observations were made in the presence of Employee #7 and Employee #8 who acknowledged the findings. | F 456 | F 456 (B)<br>1. There was no resident who was reported or observed to have been affected or harmed by this deficient practice.<br>2. The missing slat of the air curtain located at the entrance door to the prep freezer was immediately replaced on 2/24/17. A sign was posted on the outer door of the freezer to remind staff to check that all slats of air curtain is intact at all times.<br>3. An in-service was given to the morning and evening dietary production staff on 3/17/17 on the importance of keeping the slats of air curtain is intact at all times. The kitchen/dietary Monthly Safety Checklist will include checking and monitoring of the slats of air curtain.<br>4. Director of dietary department or designee will perform a daily check of the air curtain located at the front door of the prep freezer to ensure compliance. Quality Assurance Nurse will perform random checks. Any finding will be corrected immediately and will be reported to the Monthly Safety Meetings and to the QA Committee at the quarterly meetings.<br>5. Corrective action was completed on 3/17/17. | 3/17/17 |
| F 514 SS=D | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented; | F 514 | F 514<br>1. Resident #6 was not reported or observed to have been harmed by this deficient practice. On 3/1/17 Social Services designee requested a free wireless cellular phone through Assurance Wireless Free Cell Phone that is offered by the government. | |

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| F 514 | Continued from page 10<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on resident interview, observation and staff interview for one (1) of 23 stage 2 sampled residents, it was determined that the facility staff failed to document the discontinuance of telephone service (land line) for Resident #6.<br><br>The findings include:<br><br>A review of the quarterly Minimum Data Set (MDS) assessment dated January 11, 2017 revealed Resident #6's BIM's score [Brief Interview for Mental Status] was coded as 04 out of a total score of 15 under Section C, Cognitive Patterns. A score of 04 is indicative of severe | F 514 | Continued from page 10<br><br>2. No other resident has been found to have been affected or harmed by this deficient practice.<br><br>3. On 3/20/17 an in-service was given to the nursing staff and social services on the importance of reporting and documenting anything affecting telephone services for residents.<br><br>4. A log of residents who have cell phones or land line telephones in their rooms has been created. This log will be utilized monthly to assure that any interim change in the telephone service will be documented and followed up with residents as needed. Any finding will be reported to the QA Committee at quarterly meetings.<br><br>5. Corrective action was completed on 3/20/17. | 3/20/17 |

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| 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 |
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| F 514 | Continued From page 11<br><br>cognitive impairment.<br><br>A face-to-face interview was conducted on February 24, 2017 at approximately 11: 30 AM with Resident # 6. The resident responded appropriately to the pre-screening interview questions and a resident interview was conducted. During the interview; in response to the question, "Do you have privacy when on the telephone?" Resident #6 responded, "Yes", but I am not able to make a phone call from the phone in my room any more, it does not work."<br><br>At the time of the interview the phone was observed on the resident's night stand which was connected to the wall jack. However, there was no dial tone detected on the phone line.<br><br>A face-to-face interview was conducted with Employee # 2 on February 27, 2017 at approximately 3:30 pm. Employee #2 stated, "All residents are able to have a phone in their room, his/her phone should be working." Employee # 2 and the writer visited Resident # 6's room. Employee # 2 was observed to pick up the phone and stated, "Yes, I remember the [family member] discontinued the phone service but did not tell [Resident# 6]. I will discuss the phone issue with his/her [family member]".<br><br>On February 27, 2017 at approximately 4:30 PM, a face-face meeting was conducted with Employee # 2 who acknowledged the lack of documentation related to the [family/responsible party's] discontinuance of telephone service for Resident #6. The record was reviewed on February 27, 2017. | F 514 | | |