Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0016	A. BUILDING: _____ B. WING _____	03/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments An Annual Licensure survey was conducted on February 24, 2017 through March 1, 2017. The deficiencies are based on observation, record review, resident and staff interviews for 23 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)	L 000	L 091 (A) 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. 2. There was no other resident who has been reported or observed to have been affected or harmed by this deficient practice. 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. 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. 5. Corrective action was completed on 3/21/17.	3/21/17

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

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L 000	Continued From page 1 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	L 000	Continued from page 1 L 091 (B) 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. 2. There was no other resident who has been reported or observed to have been affected or harmed by this deficient practice. 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. 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. 5. Corrective action was completed on 3/21/17.	3/21/17
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: 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 for communicable disease prior to employment in	L 091		

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L 091	Continued From page 2 accordance with Centers for Disease Control and the Facility's Policy. Employee #8 and #9. The findings include: 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: "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." "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> According to the facility ' s policy " Tuberculin Surveillance" Employees; New employees will have a single or two step Mantoux administered	L 091		

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L 091	Continued From page 3 by the house ..." 1. The facility failed to ensure that Employee # 8 was pre-screened for communicable disease prior to employment. A review of Employee # 8's personnel file revealed the following: Job Title: Certified Nursing Assistant; Date of Hire: January 24, 2017 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. 2. The facility failed to ensure that Employee # 9 was pre-screened for communicable disease prior to employment. A review of Employee #8's personnel file revealed the following: Job Title: Certified Nurse Assistant (CNA); Date of Hire: November 30, 2016 There was no evidence in the employee's record that he/she received the two-step Purified Protein Derivative (PPD) skin test, a chest x-ray, or the Tuberculosis Symptom Screening Questionnaire prior to or upon employment.	L 091		

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L 091	Continued From page 4 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	L 091		
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on 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. The findings include: 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 cognitive impairment. 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	L 199	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. 2. No other resident has been found to have been affected or harmed by this deficient practice. 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. 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. 5. Corrective action was completed on 3/20/17.	3/20/17

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L 199	Continued From page 5 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." 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. 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]". 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.	L 199		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: 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	L 442	L 442 (A) 1. There was no resident who was reported or observed to have been affected or harmed by this deficient practice. 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. 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. 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. 5. Corrective action was completed on 3/17/17.	3/17/17

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L 442	Continued From page 6 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. The findings include: The door located inside the prep freezer was inadvertently closed, which allowed an area of the freezer to warm up to 37 degrees Fahrenheit (F). 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. 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. One (1) of five (5) slats from the air curtain located at the entrance door to the prep freezer was missing. These observations were made in the presence of Employee #7 and Employee #8 who acknowledged the findings.	L 442	L 442 (B) 1. There was no resident who was reported or observed to have been affected or harmed by this deficient practice. 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. 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. 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. 5. Corrective action was completed on 3/17/17.	3/17/17