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 _____	C 03/31/2023

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 000		

An unannounced Recertification Survey was conducted at this facility from March 29 - 31, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 30 and the survey sample included 16 residents.

The following Facility Reported Incidents were investigated during this survey: DC00010943, DC00010960, DC00011114, and DC00011350. There were not deficiencies identified related to the allegations of these facility reported incidents.

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

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

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sr. Alphonse Marie Jones	Administrator	4/17/2023

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	F 000		

Regulations
D/C - Discontinue
Dl - Deciliter
DMH - Department of Mental Health
DOH - Department of Health
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
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)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2 - Oxygen

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F 000	Continued From page 2 PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 16 sampled residents, facility staff failed to accurately code one resident's quarterly Minimum Data Set (MDS) assessment with the accurate number of falls. Resident #24. The findings included:	F 641	1. A modification of the quarterly Minimum Data Set assessment of Resident #24 dated 1/19/23 was completed, submitted, and accepted on 4/6/2023 to reflect the accurate number of falls sustained during the quarterly assessment. 2. All the other residents have the potential to be affected by the same deficient practice. The Risk Management section of our electronic health record system where any falls are recorded and the submitted quarterly assessments of each resident with falls were reviewed and no other resident was found to have been affected by this deficient practice.	

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F 641	Continued From page 3 Resident #24 was admitted to the facility on 05/06/21 with multiple diagnoses that included: Parkinson's Disease, Hypertension and Hypothyroidism. Review of Resident #24's medical record revealed a quarterly MDS dated 10/23/22 in which facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognitive response; and in section J (Health Conditions), no of falls since admission/entry or reentry or prior assessment, whichever is more recent. Further review of the medical record revealed the following documentation: 11/15/22 at 2:16 AM [Fall Risk Assessment] " ...Recent Fall ... Score: 12.0; Category: High Risk ... Instructions/scoring ... 10 or above [equals] High Risk ... Notes: Sustained a fall in her room ..." 11/15/22 at 3:23 AM [Nursing Progress Note] "Resident reports that approximately 12"45 a.m., she fell after using the bathroom ..." 01/04/23 at 1:00 PM [Fall Risk Assessment] " ...Recent Fall ... Score: 16.0; Category: High Risk ..." 01/04/23 at 2:20 PM [Nursing Progress Note] "At about 1:00 pm Writer was called by House keeping to the hallway who observe resident fell on the floor ..." A Quarterly MDS dated 01/19/23 in which facility staff coded: a BIMS summary score of 15; and in section J (Health Conditions), J1900 (Number of	F 641	3. An individualized fall log is maintained at each nurses' station as a secondary means of tracking falls. The specific resident's log will be reviewed at the quarterly care conference to assure that, if a resident has sustained a fall during the assessment period, it will be noted and coded accurately in the Minimum Data Set. 4. The MDS Coordinator /RAC will utilize an audit tool to record any falls that may have occurred during the quarter consistent with the facility's quarterly QAPI meeting. The QA nurse will review the report and ascertain that the number of falls and their recording on the MDS are accurate. Any discrepancies will be addressed and corrected in a timely manner. 5. The corrective action will be completed by 4/28/2023. 6. MDS Coordinator.	4/28/2023

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F 641	Continued From page 4 falls ...), "1" fall with no evidence of injury. During a face-to-face interview conducted on 03/31/23 at 12:26 PM, Employee #4 (MDS Coordinator) reviewed the MDS dated 01/23/23, acknowledged the findings and stated, "OK."	F 641		
F 656 SS=D	Cross Reference: 22B DCMR sec. 3231.12 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the	F 656	1. A comprehensive person-centered care plan of resident #29 with appropriate goals and interventions was developed and implemented on 3/31/2023 to address resident's diagnosis of convulsions and use of anti-seizure medication. 2. All other residents have the potential to be affected by this deficient practice. A general review of each resident's medication profile and related diagnoses was done with cross-reference to assure inclusion in their person-centered care plan. No other resident has been affected by this deficient practice. 3. A comprehensive review of medications and diagnoses for which they are prescribed will be done on admission and at least every 60 days in preparation for physicians' visits. If there have been any other consultants' visits, the consultation report must also be reviewed for new diagnosis and/or new medication orders and a person-centered care plan will be initiated and implemented with appropriate goals and interventions.	

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F 656	Continued From page 5 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 16 sampled residents, facility staff failed to develop and implement a comprehensive person-centered care plan with goals and interventions to address one resident's diagnosis of Convulsions and use of anti-seizure medications. Resident #29. The findings included: Resident #29 was admitted to the facility on 12/01/21 with multiple diagnoses that included: Unspecified Convulsions, Schizoaffective Disorder and Anxiety Disorder. Review of Resident #29's medical record revealed a physician's order dated 09/14/22: "Divalproex (anti-seizure medication) Sodium ER (extended release) Tablet ... 500 MG (milligrams) Give 2 tablet by mouth two times a day related to	F 656	4. The MDS Coordinator will utilize a checklist prior to each care conference to assure that all medications and diagnoses are appropriately documented in the care plans. Post each care conference, this documentation will be submitted to the QA nurse who will review to assure compliance. Any findings will be noted on the form and discrepancies will be addressed in a timely manner and discussed at each quarterly QAPI meeting. 5. The corrective action will be completed by 4/28/2023. 6. MDS Coordinator.	4/28/2023

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F 656	Continued From page 6 Unspecified Convulsions"; "Seizure precaution every shift related to Unspecified Convulsions"; and Primidone (anti-seizure medication) Tablet 50 MG Give 2 tablet by mouth two times a day related to Unspecified Convulsions". Review of Resident #24's comprehensive care plan with a review date of 02/21/23, showed no documented evidence that facility staff developed and implemented care plans with goals and interventions to address her diagnosis of Convulsions and use of anti-seizure medications. During a face-to-face interview conducted on 03/31/23 at 11:27 AM, Employee #4 (MDS Coordinator) acknowledged the findings and stated, "I don't know how I missed that." Cross Reference: 22B DCMR sec 3210.4	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657	1. The “medium risk for falls” care plan of resident #24 was revised on 3/31/23 to indicate that the resident is a "high risk for falls". Interventions were updated as appropriate to reflect that the resident is high risk for falls. 2. All other residents have the potential to be affected by this deficient practice. Fall assessment of each resident was reviewed and each resident’s level of risk has been captured and incorporated in the care plan. 3. A created form will be utilized at the time of each care conference requiring a written affirmation of having reviewed the fall risk assessment for each resident to determine that the documented risk level in the care plan is accurate.	

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F 657	Continued From page 7 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 16 sampled residents, facility staff failed to revise one resident's "medium risk for falls" care plan to "high risk for falls" after sustaining two falls. Resident #24. The findings included: Resident #24 was admitted to the facility on 05/06/21 with multiple diagnoses that included: Parkinson's Disease, Hypertension and Hypothyroidism. Review of Resident #24's medical record revealed the following documentation: 11/15/22 at 2:16 AM [Fall Risk Assessment], " ...Recent Fall ... Score: 12.0; Category: High Risk ... Instructions/scoring ... 10 or above [equals] High Risk ... Notes: Sustained a fall in her room ..." 11/15/22 at 3:23 AM [Nursing Progress Note], "Resident reports that approximately 12"45 a.m., she fell after using the bathroom ..."	F 657	This form will be completed and submitted by the MDS Coordinator to the QA nurse during care plan review and anytime a fall has occurred. Any identified discrepancies will be corrected immediately by MDS coordinator. 4. MDS Coordinator will report at the QAPI quarterly meeting on any falls that may have occurred during the quarter and that each resident's fall risk level is documented accurately in their care plan with appropriate goals and interventions. 5. The corrective action will be completed by 4/28/2023 6. MDS Coordinator.	4/28/2023

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F 657	Continued From page 8 01/04/23 at 1:00 PM [Fall Risk Assessment], " ...Recent Fall ... Score: 16.0; Category: High Risk ..." 01/04/23 at 2:20 PM [Nursing Progress Note] "At about 1:00 pm Writer was called by House keeping to the hallway who observe resident fell on the floor ..." Care plan focus area, "The resident is a medium risk for falls r/t (related to) gait/balance problems and history of fall" showed a revision date of 01/18/23. The evidence showed that facility staff failed to revise Resident #24's care plan to indicate that she is a "high risk for falls" and update the interventions as appropriate for a resident who is a high risk for falls. During a face-to-face interview conducted on 03/31/23 at 12:26 PM, Employee #4 (MDS Coordinator) reviewed the care plan, acknowledged the findings and sated, "OK." Cross Reference: 22B DCMR sec 3210.4	F 657		