| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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<br><br>A compliance survey was conducted on May 22, 2008 to determine if the plan of correction for the March 7, 2008 recertification and licensure survey was implemented. The census was 195 and the sample size was 25 residents. The following deficiencies were cited based on observations, record reviews and staff interviews. | L 000 | JB Johnson Nursing Center makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party. Its truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Law. | |
| L 001 | 3200.1 Nursing Facilities<br><br>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.<br><br>Based on an isolated observation during the tour of the facility for one (1) resident, it was determined that facility staff failed to ensure that Resident #4 was provided privacy during AM care.<br><br>The findings include:<br><br>On May 22, 2008 at approximately 9:50 AM, Employee #4 was observed retrieving articles from the resident's closet. Resident #4 was observed naked, seated in a chair next to his/her bed. There were privacy curtains, but they were not drawn around the resident. | L 001 | 1. The door to resident #4's room was closed and the privacy curtain was pulled around the resident immediately. No other residents were affected by this practice.<br><br>2. A tour of the other units was conducted and no other resident was found to be affected by this practice.<br><br>3. A meeting was conducted with the Nursing leadership staff. They were re-educated on facility policies particularly as it pertains to resident's rights. Each nursing manager will provide on unit training to the nursing staff.<br><br>4. Monitoring of resident's privacy is conducted monthly by the nursing management team. This is reported in the Quality Improvement Assurance Meeting. | 7/01/08 |
| L 051 | 3210.4 Nursing Facilities<br><br>A charge nurse shall be responsible for the following:<br><br>(a)Making daily resident visits to assess physical | L 051 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 051 | Continued From page 1<br><br>and emotional status and implementing any required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(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:<br><br>Based on record review and staff interviews for five (5) of 25 sampled residents, it was determined that the charge nurse failed to ensure that one (1) resident received a cystoscopy and that one (1) resident received an ENT (Ear, Nose and Throat) consultation as ordered , inform the physician of one (1) resident verbally abusive behavior, follow the physician's order for a cardiologist follow up appointment for one (1) resident and revise the care plan for one (1) resident who was verbally abusive. Residents #5, 6, 15, 17 and 20.<br><br>The findings include:<br><br>1. The charge nurse failed to ensure that Resident #5 was rescheduled for a cystoscopy. | L 051 | 1. Residents # 5, 6, 15, 17 and 20 were reassessed by the nursing management team. Residents # 5, 6 and 17 have had appointments rescheduled. Responsible party and MD were notified. The physician was aware of resident #15's verbally abusive behavior. Unable to retrospectively correct; however, the physician has addressed the resident's behavior. A care plan was in place to address resident #20's verbally abusive behavior. This resident's care plan was updated immediately for each incident cited in the nursing notes. The resident has been seen by the physician and the Plan of Care was modified.<br><br>2. A review of the clinical records including consultations, appointments, and physicians orders was conducted. Additionally a review of the care plans was conducted particularly as it pertains to behavior. No other resident were found to be affected by this practice.<br><br>3. The unit clerks have been re-educated regarding the process for scheduling and ensuring that the resident appointment is scheduled and conducted. A conference was done with the Ombudsman and Social Work regarding Resident #20's abusive behavior and resident was referred to psychiatrist for anger management. Staff re-educated on updating Care Plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 051 | Continued From page 2<br><br>A physician's order dated April 28, 2008 at 4:00 PM directed, "T/O (telephone order) ... Cystoscopy. Outpatient local scheduled for 5/5/08 @ 9:30 @ [hospital name]."<br><br>A urology consult dated April 28, 2008 revealed: "Prostate exam - large prostate with no other specific palpation findings. [Resident] will need cystoscopy and prostate biopsy.<br><br>The record included a PSA (Prostatic Specific Antigen) level of 25.2 ng/ml with a normal range of 0.0 - 4.0. Prostate Specific Antigen is a protein produced by the prostate cells. A PSA test is a blood test that doctors use to measure prostate health. A high PSA level can be a sign of enlarging prostate or prostate cancer [http://www.prostatecare.com].<br><br>The nurse's notes dated May 5, 2008 at 3:00 PM included, "...Resident returned [to] unit at 10:55 AM from appt. Cystoscopy not done. Writer understands that resident does not have coverage of medicare or Medicaid at this moment therefore [resident] cannot be attended to. Resident will be rescheduled as soon as this is resolved.<br><br>A face-to face interview was conducted with Employee #2 on May 22, 2008 at 11:05 AM. He/She stated, "We book appointments, but they say that [resident] can't come. It's something wrong with [resident's] insurance. The social worker is aware".<br><br>A face-to-face interview was conducted with Employee #8 on May 22, 2008 at 12:20 PM. He/She stated, "I don't know about him/her".<br><br>A telephone interview was conducted with | L 051 | 4. The comprehensive Nursing Medical Record Audit addresses appointments, notification of MD, recommendations, and Care Plans. This tool is conducted monthly and is presented at the Quality Assurance and Improvement meetings. | 7/01/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 051 | Continued From page 3<br><br>Employee #9 on May 22, 2008 at 1:20 PM. He/She stated, "I talked to the business office and was told that [resident] had Medicaid. I don't know what's going on".<br><br>As of the date of this survey, May 22, 2008, the cystoscopy had not been rescheduled for Resident #5 and there was no new information regarding the reason for the delay. The record was reviewed on May 22, 2008.<br><br>2. The charge nurse failed to ensure that Resident #6 was scheduled for an ENT consult.<br><br>Physician's order directed, "4/14/08 at 12 noon ...ENT consult for laryngoscopy for hoarseness" and" 4/29/08 at 8:20 PM Pen Vee K 500 mg p.o. 4 times a day for 10 days for pharyngitis."<br><br>A face-to-face interview was conducted with Employee #2 on May 22, 2008 at 11:10 AM. He/She stated, "[Resident has a problem with insurance. His/her appointment was cancelled. He/she is not hoarse. He/she was on antibiotics and it was effective.<br><br>A face-to-face interview was conducted with Employee #8 on May 22, 2008 at 12:20 PM. He/She stated, "I checked with finance. I brought it to the RCC (Resident Care Coordinator) of that unit. Transportation will take [resident] there. [Resident] has a level of care in the chart that goes through July. I brought it to my supervisor. They were going to try and work with a different physician."<br><br>A telephone interview was conducted with Employee #9 on May 22, 2008 at 1:20 PM. He/She stated, "I talked to the business office and was told that [resident] had Medicaid. I don't | L 051 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 051 | Continued From page 4<br>know what's going on".<br><br>As of the date of this survey, May 22, 2008, the ENT appointment had not been rescheduled for Resident #6 and there was no new information regarding the reason for the delay. The record was reviewed on May 22, 2008.<br><br>3. The charge nurse failed to notify the physician of Resident #'15's verbally abusive behavior of staff.<br><br>. A review of Resident #15's record revealed the following nurse ' s notes: " May 11, 2008 at 11:00 ...Resident ...bursted out very angry and verbally abusing writer, calling writer stupid [and using profane words] ... "<br><br>A face-to-face interview was conducted with Employee # 7 on May 22, 2008 at approximately 10:45 AM. He/she acknowledged at the time of the interview, that the resident ' s record lacked evidence that the physician was notified of the resident verbally abusive behavior of staff on May 11, 2008.<br><br>4. The charge nurse failed to perform the physician ' s order for a cardiologist follow up appointment and failed to notify the physician and responsible party that the order was not performed. Resident # 17<br><br>A Review of the nurses' notes revealed the following:<br>April 9, 2007 at 11:00 PM: "...F/U follow up appointment rescheduled for 5/12/08 as resident was not seen by the cardiologist..."<br><br>A review of the resident's record reveal an | L 051 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 051 | Continued From page 5<br><br>Interim Order Form dated and signed by the physician on April 11, 2008 that indicated "F/U cardiology Appt. rescheduled for 5/12/08 ..."<br><br>The resident ' s record lacked evidence that the: resident was seen for the cardiology follow up, primary care provider and responsible party were notified that the order was not followed or why it was not done.<br><br>A face-to-face interview was conducted with Employee # 6 on May 22, 2008 at approximately 11:45 AM. He/she acknowledged that the resident ' s record at the time of interview lacked evidence that the charge nurse performed the physician ' s order for a follow-up cardiologist appointment and informed the physician and responsible party that the order for follow up cardiologist appointment was not performed. The record was reviewed May 22, 2008<br><br>5. The charge nurse failed to revise Resident #20's care plans after episodes of verbal abuse.<br><br>A review of Resident #20's record revealed the following nursing notes:<br><br>April 16, 2008 at 8:00 AM: "Non-compliant with care, refused blood draw ... became verbally abusive towards phlebotomist ..."<br><br>May 13, 2008 at 6:45 AM: "Refused blood draw ...writer told resident to stop using abusive language towards employees and phlebotomist ..."<br><br>According to Care plan #4: "Resident has physical and verbally abusive behavioral symptoms i.e. others threatened, screamed at, | L 051 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 051 | Continued From page 6<br>cursed at."<br><br>The care plan was last updated on March 24, 2008. There was no evidence that additional interventions were initiated or that the care plan was revised after the aforementioned incidents.<br><br>A face-to-face interview was conducted with Employee #5 on May 22, 2008 at 12:15 PM. He/she stated, "[Resident #20] continues to be verbally abusive. We are trying to find [Resident #20] alternative placement. " The record was reviewed May 22, 2008. | L 051 | | |
| L 052 | 3211.1 Nursing Facilities<br><br>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:<br><br>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;<br><br>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:<br><br>(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;<br><br>(d) Protection from accident, injury, and infection;<br><br>(e)Encouragement, assistance, and training in self-care and group activities;<br><br>(f)Encouragement and assistance to: | L 052 | 1. Facility maintains a staff ratio far in excess of Federal and District requirements. Resident #2 was reassessed and no neurological deficits were noted. Unable to retrospectively correct neuro checks. Resident #23 was immediately provided hygienic care.<br><br>2. All charts were reviewed for neuro checks, no other residents were found to be affected by this practice. Rounds were conducted and no other resident was found to need hygienic care.<br><br>3. A meeting was conducted with the Nursing leadership staff who were re-educated on facility policies as it pertains to neuro checks and ADLs. Each nursing manager will provide on unit training to the nursing staff. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 052 | Continued From page 7<br><br>(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;<br><br>(2)Use the dining room if he or she is able; and<br><br>(3)Participate in meaningful social and recreational activities; with eating;<br><br>(g)Prompt, unhurried assistance if he or she requires or request help with eating;<br><br>(h)Prescribed adaptive self-help devices to assist him or her in eating independently;<br><br>(i)Assistance, if needed, with daily hygiene, including oral acre; and<br><br>j) Prompt response to an activated call bell or call for help.<br><br>This Statute is not met as evidenced by:<br><br>Based on observations and staff interview for two (2) of 25 sampled residents, it was determined that sufficient nursing time was not provided to ensure that one (1) resident was assisted with daily personal grooming as evidenced by a strong smell of urine from the resident and that one (1) resident had neurological checks performed as ordered by the physician. Resident #2 and 23.<br><br>The findings include:<br><br>1. Facility staff failed to provide sufficient nursing time to ensure that Resident #2 had neurological (neuro) checks as ordered by the physician.<br><br>Physician orders directed: May 6, 2007 at 10:30 AM, " T.O. (telephone order) ... Neuro check x | L 052 | 4. Monitoring of documentation and residents grooming is a part of the nursing management audit tools. This information is reported at the Quality Improvement and Assurance meeting. | 7/01/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 052 | Continued From page 8<br>48 hrs S/P (status post) fall ... "and May 11, 2008 at 8:05 AM, "T.O. ... Neuro check x 48 hrs S/P fall. "<br><br>A review of the Neuro flow sheets revealed the following:<br><br>Neuro checks were performed on May 6, 2008 starting at 10:30 AM to May 7, 2008 at 2:00 PM. [duration 27.5 hours].<br><br>Neuro checks were performed on May 11, 2008 starting at 5:00 PM to May 12, 2008 at 4:00 AM. [duration 35 hours].<br><br>A face-to-face interview was conducted with Employee #3 on May 22, 2008 at approximately 10:00 AM. Employee #3 was asked for the neuro check sheets for the 48 hour monitoring for May 6 and 11, 2008. Employee #3 presented this surveyor with two (2) neuro check sheets for the May 6, 2008 order and two (2) sheets for the May 11, 2008. He/She acknowledged that the neuro check monitoring was not performed for 48 hours. The record was reviewed on May 22, 2008.<br><br>2. Facility staff failed to provide sufficient nursing time to Resident #23 to ensure that he/she was clean and free from body odor.<br><br>On May 22, 2008 at approximately 9:40 AM during the tour of unit 1 North, there was a strong smell of urine noticed upon entering Resident #23's room. Resident #23 was observed lying in bed and his/her roommate was seated in a chair. The urine smell was coming from Resident #23's side of the room.<br><br>The most recent quarterly Minimum Data Set | L 052 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 052 | Continued From page 9<br>dated April 1, 2008 coded the resident in Section G (Physical Functioning and Structural Problems) as requiring extensive assistance for toilet use and limited assistance for personal hygiene and as incontinent of bladder in Section H (Continence in last 14 days).<br>The record was reviewed on May 22, 2008.<br><br>At approximately 10:30, Employee #3 was in Resident #23's room administering medication to the roommate. Employee #3 acknowledged that the urine smell was from Resident #23. | L 052 | | |
| L 108 | 3220.2 Nursing Facilities<br><br>The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident.<br><br>This Statute is not met as evidenced by:<br>Based on the observation of a test tray conducted on May 22, 2008, it was determined that facility staff failed to ensure that cold food did not exceed 45 degrees Fahrenheit (F) and hot foods were served above 140 F at the point of delivery to the resident. The temperatures were measured in the presence of Employee #12.<br><br>The findings include:<br><br>On May 22, 2008, trays were delivered to unit 4 North at 8:49 AM. The test tray temperatures were taken at 9:05 AM and the following food temperatures were recorded in the presence of Employee #12:<br><br>Fat free Milk - 54.4 F<br>Orange Juice - 55.9 F | L 108 | 1. The breakfast meal is a difficult meal to maintain temperature compliance; however facility staff will re-check food items as needed. Facility cannot retrospectively correct the varying temperatures on test tray.<br><br>2. A review of resident meal service was conducted and no resident was affected by this practice.<br><br>3. Facility will maintain extra milk or juice on the unit in the pantry refrigerator. Additionally, during Resident Council, residents will be reminded that staff will be delighted to reheat food items particularly the breakfast meal.<br><br>4. Monitoring of dining room tray service is a part of the quality improvement program and is presented in the Quality Assurance meeting. | 7/01/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 108 | Continued From page 10<br>Pureed scrambled Eggs - 115.0 F<br>Pureed meat - 125.0 F<br>Sausage patty - 100.1 F<br><br>Employee #12 acknowledged the findings at the time of the observations. | L 108 | | |
| L 161 | 3227.12 Nursing Facilities<br><br>Each expired medication shall be removed from usage.<br>This Statute is not met as evidenced by:<br>Based on observation of medication carts on two (2) of seven (7) nursing units, it was determined that facility staff failed to ensure that expired medications were removed from usage. Residents #21 and 22.<br><br>The findings include:<br><br>1. On May 22, 2008 at 9:08 AM on Unit 1 South, the medication cart was checked. A blister package containing 18 tablets of Acetaminophen 325 mg was observed in the medication cart for Resident #21. The expiration date for the Acetaminophen was October 2007.<br><br>Employees #1 and #2 acknowledged that the Acetaminophen was expired at the time of the observation.<br><br>2. On May 22, 2008 at 9:55 AM on Unit 3 North, the medication carts were checked. A blister package containing 23 tablets of Oxycodone 5 mg was observed in one of the medication carts for Resident #22. The expiration date for the Oxycodone was April 4, 2008.<br><br>Employee #5 acknowledged that the Oxycodone was expired at the time of the observation. | L 161 | 1. All expired medications were removed and discarded/disposed of immediately.<br><br>2. A review of all medication carts was conducted and no expired medications were found. No other resident was found to be affected by this practice.<br><br>3. Every Tuesday and Friday a medication audit is performed. The night shift will pull all expired medications discard and/or dispose of appropriately.<br><br>4. An audit of the medication cart is conducted by nursing management. This information is provided to the Quality Assurance Improvement Committee. | 7/01/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 410 | 3256.1 Nursing Facilities<br><br>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.<br>This Statute is not met as evidenced by:<br>Based on observations during the environmental tour, facility staff failed to follow the Plan of Correction for the annual recertification and licensure survey completed March 7, 2008 as evidenced by soiled interior surfaces of the HVAC (Heating Ventilation Air Condition) units and caulking in shower rooms.<br><br>These observations were made on May 22, 2008 from 9:05 AM through 11:45 PM in the presence of Employees #10 and 11.<br>The findings include:<br><br>1. The interior surfaces of HVAC units were observed with accumulated dust and debris.<br><br>According to the Plan of Correction for the annual recertification and licensure survey completed March 7, 2008, "...interior surface of HVAC units have been cleaned ...during monthly and quarterly filter changes the HVAC will be cleaned with a shop vac." with a completion date of April 25, 2008.<br><br>The interior surfaces of HVAC units were observed with accumulated dust and debris in the following resident rooms: 207, 210, 211, 215, 219, 410, 411, 415, 415, 419, 426, and 433 in 12 of 28 resident rooms.<br><br>A face-to-face interview was conducted the Employee #11 during the time of the | L 410 | 1. The interior surfaces of the HVAC units identified in the survey were cleaned. The grouting identified in the shower rooms was steam cleaned and the caulking was redone. No resident was affected by this practice.<br><br>2. All HVACs at the facility were checked and cleaned as indicated. All shower rooms were checked and no other shower room was impacted by this practice.<br><br>3. The Preventive Maintenance Program (PMP) on the HVAC has been modified to include utilization of the "shop vac" to clean the unit when needed. The units are checked when changing filters. In consultation with the Environmental department the Engineering staff will caulk the shower rooms as needed.<br><br>4. The Director of Engineering monitors the resident's rooms and common areas monthly. This includes HVAC and shower rooms. This information is presented to the Quality Assurance Improvement Committee. | 7/01/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 05/22/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 410 | Continued From page 12<br><br>observations. He/she stated, "We tried different cleaning products, but the smell bothered the residents. I think we have found one that will work. The shop vac just didn't do the job. I wasn't aware that it all had to be done by April 25, 2008. "<br><br>Employees #10 and 11 acknowledged the findings at the time of the observations.<br><br>2. Caulking in shower rooms was observed soiled with accumulated debris.<br><br>According to the Plan of Correction for the annual recertification and licensure survey completed March 7, 2008, "...caulking of the shower rooms ...was completed." with a completion date of April 25, 2008.<br><br>Soiled caulking was observed in the following shower rooms:<br>1 North in two (2) of three (3) shower rooms observed<br>1 South in two (2) of three (3) shower rooms observed<br>2 North in three (3) of three (3) shower rooms observed<br>2 South in one (1) of three (3) shower rooms observed<br>4 North in two (2) of three (3) shower rooms observed<br><br>Employees #10 and 11 acknowledged these findings at the time of the observations. | L 410 | | |