Health Regulation 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 _____	03/12/2009

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 March 11 through 12, 2009. The following deficiencies were based on record review and staff interview. The sample size was 10, based on a census of 39 residents on the first day of survey.	L 000		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served in a safe and sanitary manner as evidenced by: foods observed undated in two (2) of four (4) walk-in refrigerators: 16 of one (1) case of undated tomatoes with green, white and black spots on the tomatoes, one (1) of two (2) trays of lunch meat and one (1) of two (2) containers of dried berries, and one (1) of one (1) dry storage area; and damaged ceiling in one (1) of one (1) holding area. The tour of the main kitchen was conducted on March 11, 2009 from 9:15 AM until 10:20 AM. These findings were acknowledged by Employee #1 at the time of the observations. The findings include: 1. The following foods were observed undated in the walk-in refrigerator and the dry storage area: A. 16 of one (1) case of tomatoes observed with green, white and black spotted areas on the tomatoes.	L 099	1. The spotted tomatoes and the undated dried berries were disposed of immediately in the presence of the surveyor during the inspection. The plate of assorted lunch meats and cheese were labeled and dated during the inspection. The packages of improperly stored turkey were disposed of immediately in the presence of the surveyor during the inspection. The cracked outer layer of the sheet rock ceiling in the holding area was peeled away and the area skimmed, refinished and sealed with a 100% acrylic coating and mold and mildew-resistant kitchen gloss. Ceiling repair was completed on March 30, 2009. 2. All produce will be inspected daily by designated dietary staff. Any item(s) found to be of inferior quality or improperly stored will continue to be discarded. 3. An inservice education session was conducted by the food service manager for the kitchen staff on March 13th reviewing methods which ensure the maintenance of sanitary conditions: proper storage, labeling, preparation, distribution and serving of food.	3/30/09

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L 099	Continued From page 1 B. One (1) of two (2) trays of assorted lunch meat and cheese undated. C. One (1) of two (2) containers of dried berries undated in the dry storage area 2. The following was observed improperly stored in the walk-in refrigerator: Six (6) of six (6) packages of mechanically separated turkey was observed stored in walk-in refrigerator. The manufactures label [on the package] directed, " Keep Frozen " .	L 099	4. The food service manager will monitor on a weekly basis through visual inspection the correct storage, labeling and dating of all foods. Any findings will be corrected and reported to the Quality Improvement/Quality Assurance committee with appropriate follow-up in the dietary department and further inservice as indicated.	
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and	L 128	1. The charts of Residents' #1, 2, and 6 were reviewed by the pharmacist on March 25th to ensure that either dosage reduction was ordered or documentation was provided for not attempting it by the attending physician or psychiatrist. Appropriate documentation has been completed by the attending physicians of the above-listed Residents as of the date of the pharmacist's review. 2. To prevent future occurrences, all Residents on psychotropic medications will be monitored on a monthly basis to ensure that dosage reduction is attempted and/or appropriate documentation provided. If neither one is provided on a timely basis, written notification to the physician will be generated by the pharmacist to request this action. 3. All recommendations by the consulting pharmacist regarding psychotropic	3/25/09

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L 128	Continued From page 2 (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interviews for three (3) of 10 sampled residents, it was determined that the pharmacist failed to report to the physician and Director of Nursing that dose reduction for the use of antipsychotic medications had not been attempted for Residents #1, 2, and 6. The findings include: 1. The Pharmacist failed to report the physician and Director of Nursing that an attempted dose reduction for Resident #1, who was receiving Seroquel, had not been attempted. A review of Resident #1's record revealed a physician's order initiated March 23, 2008, directing, "Seroquel 25 mg twice daily for Anxiety and Agitation." The above cited order was renewed May 16, July 15, September 17, November 15, 2008, January 16, 2009 and March 10, 2009. A review of the Medication Administration Record (MAR) for March 2008 through March 2009 revealed that the resident received Seroquel 25 mg by mouth twice daily while in the facility. A review of the Behavioral Management Flow Sheet revealed that Resident #1 was agitated 29 times from March 2008 through March 2009. According to the "Chronological Record of Drug Regimen Review," the pharmacist conducted a review of the resident's medication on, April 14,	L 128	medications and appropriate follow-up will be reported to the DON, ADON, and administrative staff on a quarterly basis. 4. A list of Residents receiving any psychotropic medications (antipsychotics, anxiolytics, antidepressants, etc.,) will be provided by the pharmacy on a monthly basis prior to the monthly drug regimen review. This list will form the basis of monitoring whether dosage reduction or appropriate documentation by the attending physician or psychiatrist has been done in a timely manner since initiation of the medication. These reports will be reviewed by the Quality Improvement/Quality Assurance committees to ensure compliance and to take further action if indicated.	

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L 128	Continued From page 3 May 15, June 12, July 15, August 14, September 15, October 10, 2008, November 12, and December 12, 2008 and January 12, and February 16, 2009. There was no evidence that the pharmacist reported to the physician and Director of Nursing that a gradual dose reduction for Seroquel was not attempted since the medication was ordered on March 23, 2008. A face-to-face interview was conducted with Employee #4 on March 11, 2009 at 10:30 AM. He/she acknowledged that there were no irregularities reported by the pharmacist regarding the use of Resident #1's Seroquel. The record was reviewed March 11, 2009. 2. The Pharmacist failed to report the physician and Director of Nursing that an attempted dose reduction for Resident #2, who was receiving Risperdal, had not been attempted. A review of the Physician ' s Order Sheets (POS) in the resident ' s clinical record revealed that the resident was started on Risperdal on July 15, 2008. The order directed the following: " Risperidone Tab 0.5mg for Risperdal, Take 1 tablet by mouth at bedtime for anxiety. The medication was last reordered on February 17, 2009. A review of the Medication Administration Record (MAR) for March 2008 through March 2009 revealed that the resident received Risperdal 0.5 mg at bedtime daily while in the facility. A review of the Pharmacist ' s Review Sheets revealed that the pharmacist reviewed the resident ' s clinical record on July 15, 2008,	L 128		

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L 128	Continued From page 4 August 14, 2008, September 15, 2008, October 10, 2008, November 12, 2008, and December 12, 2008, and January 12, 2009 and February 16, 2009. There was no evidence that the pharmacist recommended attempting a dose reduction of Risperdal for any of those months. A face-to-face interview was conducted with Employee #4 on March 12, 2009 at approximately 11:40 AM. He/she acknowledged that the record lacked documented evidence of any attempt to reduce the dose of the Risperdal. The record was reviewed on March 11, 2009. 3. The Pharmacist failed to report the physician and Director of Nursing that an attempted dose reduction for Resident #6, who was receiving Zoloft, had not been attempted. A review of Resident #6's record revealed a physician ' s order initiated February 5, 2008 that directed "Zoloft 100 mg po qd [by mouth daily]." The order was renewed March 4, 2008, April 29, 2008, June 24, August 9, 2008, October 14, December 9, 2008 18, and February 3, 2009. According to the MAR for March through December 2008 and January through March 11, 2009, the resident received Zoloft 100 mg daily at 7:00 PM while in the facility as evidenced by the nurses ' initials in the designated area documenting that the medication had been administered. A review of Resident #6's record revealed that the physician visited the resident on August 9, October 14, and December 9, 2008, and January 3, 2009 as evidenced by the physician ' s progress notes in the resident ' s clinical record.	L 128		

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L 128	Continued From page 5 The pharmacist documented on the "Chronological Record of Medication Regimen Review" that a monthly review of medications was conducted on May 15, June 12, July 15, August 14, September 15, October 10, November 12, and December 12, 2008 and January 12, February 16, and March 11, 2009. The pharmacist indicated that there was "No Recommendation Made" regarding the resident's medications for each review. A face-to-face interview was conducted with Employee #4 on March 11, 2009 at 10:30 AM. He/she acknowledged that there were no irregularities reported by the pharmacist regarding the use of Resident #1's Seroquel. The record was reviewed March 11, 2009.	L 128		
L 410	3256.1 Nursing Facilities 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. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: two (2) of three (3) soiled roller carts in the beauty shop. The environmental tour was conducted on March 11, 2009 at 12:30 PM in the presence of two (2) Beauty Shop staff. The findings were acknowledged at the time of the observations.	L 410	1. The curlers were disinfected as per procedure and the curler carts cleaned on March 11th immediately following the inspection tour. 2. The curler carts will be checked on a weekly basis and cleanliness and sanitary measures ensured after each beautician visit. 3. The responsible staff person was in-serviced by the supervisor on the proper procedures on March 13th. A log will be maintained with the date that the carts were checked and cleaned. 4. A member of the Quality Assurance Committee will review the logs on a weekly basis and will do random	3/18/09

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L 410	Continued From page 6 The findings include: Two (2) of three (3) hair roller carts were observed soiled with hair and a brown substance in the beauty shop.	L 410	checks to assure that the carts are kept clean and orderly and curlers have been disinfected.	

Jean Jugan Resident Roster
January 22-23, 2008

1. Resident #9 – Eliane Pitman
2. Resident JH1 - Arsenia M. Gonzales