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 _____	10/24/2019

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 Jeanne Jugan Residence from October 21, 2019 through October 24, 2019. Survey activities consisted of a review of 19 sampled residents. The following deficiencies are based on observation, record review 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.

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
CPR- Cardiopulmonary Resuscitation
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)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sr. Alphonse Marie Jones	Administrator	11/27/2019

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 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) 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 Trach- Tracheostomy	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-	F 622		

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F 622	Continued From page 2 (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622	1. Residents #18 and #31 were affected by this deficiency. Retrospectively, corrective action cannot be accomplished for these two (2) residents as both of them have already returned to the facility. 2. Every resident has the potential of being affected by this deficiency. Re-education and review of our hospital transfer form procedure and checklist, along with some added revisions will be done for all licensed nursing staff. All required documents and pertinent information accompany the resident to the receiving institution. 3. The completed checklist will be signed by the charge nurse and will be placed in the resident's chart along with the copy of the transfer form. 4. QA nurse or designee will review the completed checklist of documents sent for each resident transfer to assure compliance. Any finding will be reported to the DON/ADON for immediate follow up and reinservicing. A summary of findings will be submitted at the quarterly QAPI meeting. 5. Corrective action will be completed by 12/02/19.	12/02/19

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F 622	Continued From page 3 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a	F 622		

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F 622	Continued From page 4 copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for two (2) of 19 sampled residents, facility staff failed to ensure that when one (1) resident was transferred to the hospital, a completed transfer form and all pertinent information regarding the resident's care was sent to the receiving institution, and failed to document in one (1) resident's medical record information sent to the receiving health care institution. Resident's #18 and #31 Findings included... 1.Facility staff failed to ensure that when Resident #18 was transferred to the hospital a completed transfer form and all pertinent information regarding the resident's care was conveyed to the receiving institution. Resident #18 was admitted to the facility on 9/07/18, with diagnoses to include End-stage Renal Disease, Peripheral Vascular Disease, Diabetes Mellitus, Hypertension, Osteoarthritis, and Anxiety. A review of the Quarterly Minimum Data Set [MDS] dated 8/23/19, showed Under section [Cognition] Brief Interview for Mental Status [BIMS] the resident was recorded as "14" which	F 622		

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F 622	Continued From page 5 indicates cognition intact. A review of the Physician Interim order form dated 10/7/19 at 18:51 PM showed, "Transfer resident to [hospital name] ER [emergency room] via non-emergency ambulance for evaluation of AMS [altered mental status] and intermittent SOB [shortness of breath] at the dialysis center today." During a face-to-face interview with Employee #7 on 10/23/19 at approximately 10:10 AM the employee presented a Transfer/Discharge Report Form dated 10/7/19. Review of this form showed an incomplete transfer form and facility staff failed to send all pertinent information such as, the name of the physician in charge at the time of transfer name, advance directives, special instructions/precautions for continued care, comprehensive care plan goals, medications including when last received, recent labs, diagnostic tests, recent immunization status and complete diet type [renal low phosphorus, low potassium] and all information necessary to address the resident's behavioral needs and mental status) to the receiving institution (area hospital). A face-to-face interview was conducted on 10/23/19 at approximately 10:00 AM with Employee#5. He acknowledged the finding. 2. Facility staff failed to document Resident #31 medical record information sent to the receiving health care institution and Hypothyroidism.	F 622		

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F 622	Continued From page 6 Resident #31 was admitted to the facility on 6/25/19 with diagnoses Essential Hypertension, Presbyopia, Age-related Osteoporosis, Atrial Fibrillation Review of the Annual Minimum Data Set [MDS] dated 7/4/19 showed Section C (Cognitive Patterns) Brief Interview or Mental Status [BIMS] the resident was coded as having a scored of "6" which indicates severe cognitive impairment. Review of the progress note dated 10/20/19 showed Resident #31 was sent out to the hospital in a non-emergency ambulance for "worsening periorbital edema." Further review of the resident's record did not show that information was given to the receiving health care institution to include the following: contact information of the practitioner responsible for the care of the resident, special instructions or precautions for ongoing care, discharge summary and comprehensive care plan goals. During a face-to-face interview on 10/23/19 at approximately 4:30 PM, Employee #7 acknowledged the finding.	F 622		
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.	F 657	1. Resident # 33 was affected by this deficiency. The care plan of resident #33 was updated on 11/22/19 by RNAC/MDS Coordinator to include the specific recommendations of rehabilitation services. 2. All other residents have the potential to be affected by this deficiency. Rehabilitation services and other consultants will use an	

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F 657	Continued From page 7 (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 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 (1) of 19 sampled residents, facility staff failed to update/revised Resident # 33's care plan to include the recommendations of rehabilitation services. Findings included... Resident #33 was admitted to the facility on 6/22/16, with diagnoses Essential Hypertension, Hyperlipidemia, Alzheimer Disease and Depression. Review of the Quarterly Minimum Data Set [MDS] dated 7/4/19, showed Section C (Cognitive Patterns) Brief Interview or Mental Status [BIMS]	F 657	interdisciplinary communication form when making a recommendation. 3. Completed interdisciplinary communication forms will be submitted to DON/ADON for review and a copy will be furnished to RNAC/MDS Coordinator. 4. ADON or designee will review updated/revised care plans on a weekly basis to ensure that any new recommendations or orders have been implemented. Any finding and action taken will be documented. A summary log will be submitted at the quarterly QAPI meeting. 5. Corrective action will be completed by 12/02/19.	12/02/19

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F 657	Continued From page 8 the resident was scored as "2" which indicates severe cognitive impairment. Section G0600 Mobility Devices showed walker and wheelchair were checked to indicate the residents use of device for ambulation. Review of Section J [Health Conditions] showed J1700 Fall History on Admission and prior to admission was left blank. Review of the care plan showed "resident is high risk for falls r/t (related to) confusion, unsteady gait and multiple falls." Further review of the medical record showed therapy notes dated 8/13/19, "Resident requires the use of a wheelchair for distance greater than 50 feet; resident can use a walker however her status may change from close supervision to moderate assistance for functional ambulation using rolling walker." Facility staff failed to update/revise care plan to include the use of a wheel chair for greater than 50 feet and level of supervision when using a rolling walker. During a face-to-face interview on 10/22/19 at 4:30 PM Employee #7 acknowledged the finding.	F 657		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812	1. All residents have the potential to be affected by this deficiency. a. The bottom of the two (2) convection ovens, as well as their shelves were cleaned at the end of the day, 10/21/19 by a kitchen staff member.	

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F 812	Continued From page 9 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to prepare and serve foods under sanitary conditions as evidenced by two (2) of two (2) soiled convection ovens and 14 of 14 damaged frying pans that were stored on a ready-for-use shelf. Also, facility staff failed to store cooking utensils under sanitary conditions as evidenced by 19 of 19 sheet pans that were stacked wet on a ready-for-use shelf. Findings included... During observations of dietary services on October 21, 2019, at approximately 9:20 AM: 1. Two (2) of two (2) convection ovens were soiled at the bottom and at the shelves with burnt food deposits. 2. The cooking surfaces of 14 of 14 frying pans of various sizes, stored on a ready-for-use shelf, were scratched and the coating material had	F 812	b. The 14 scratched frying pans with flaked coating material were immediately removed from the shelves and placed in the dumpster for removal. c. The 19 sheet pans that were stacked wet on a ready for use shelf were immediately removed, re-sanitized and allowed to air dry before re-storage. 2. a. The Food Service Director in-serviced kitchen staff including cooks and utility workers on proper cleaning of the convection ovens. b. All kitchen staff were in-serviced regarding immediate and proper disposal of any cooking utensils that are damaged. c. Kitchen utility workers were re-instructed regarding proper drying procedure for all cooking utensils including sheet pans which must be allowed time for drying before restacking on ready to use shelf. 3. a. Convection ovens will be cleaned before the end of the day anytime they are used. Dates of the use will be logged and proper cleaning will be noted with initials of worker responsible for cleaning.	

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F 812	Continued From page 10 flaked off throughout. 3. During a walkthrough of dietary services on October 21, 2019, at approximately 9:20 AM, 19 of 19 sheet pans that were stacked wet on a ready-for-use shelf. Employee #4 acknowledged the finding during a face-to-face interview on October 21, 2019, at approximately 10:30 AM.	F 812	b. Kitchen staff will check cooking utensils for any damage on a daily basis. If damage is noted it will be reported to the Food Service Director or Assistant Manager who will assure appropriate disposal and replacement as necessary. c. Sheet pans will be air dried after being run through the dishwashing cycle. Kitchen utility staff will ensure that they are thoroughly dry before stacking and storing them for use. If they do not air dry properly, this will be reported promptly to the Food Service Director or Assistant Manager as water temperature adjustment maybe needed. 4. a. The Assistant Manager will review the convection oven cleaning log weekly and take appropriate action for any problem. b. The Assistant Manager will check all pots and pans to assure that any protective surfaces are intact on a weekly basis. c. A weekly random check of sheet pan drying and storage process will be done by the Assistant Manager Any finding will be recorded on a log and a summary will be submitted at the quarterly QAPI meeting. 5. Corrective action will be completed by 12/02/19.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		12/02/19

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F 842	Continued From page 11	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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JEANNE JUGAN RESIDENCE	4200 HAREWOOD ROAD NE WASHINGTON, DC 20017

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F 842	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 19 sampled residents, facility staff failed to document that one (1) resident had an abrasion on the left side of her face. Resident #10. Findings included... Resident #10 was admitted to the facility on 7/30/19, with diagnoses to include Hyperlipidemia, Hypertension, Dementia, and Dysphagia. Review of the Admission Minimum Data Set [MDS] dated 9/28/19 showed under section [Cognition] Brief Interview for Mental Status [BIMS] the resident was coded as "05" which indicates severe cognitive impairment. During the survey, tour on 10/21/19 at approximately 3:28 PM, Resident #10 was observed with an abrasion on the left side of her face. During a telephone interview with [the resident's responsible party] on 10/21/19, he stated, "Mother scratched herself on left side of face and the nurses are taking care of it." A review of the medical record dated 10/19/19 - 10/21/19 showed the abrasion on the resident's left side of the face was not documented. A face-to-face interview was conducted with Employee #6 on 10/23/19 at approximately 11:00	F 842	1. Resident #10 was affected by this deficiency. A late entry nursing progress note was written by charge nurse #5 on 10/23/19 documenting resident's abrasion on the left side of her face. 2. All other residents have the potential to be affected by this deficiency. Charge nurse #5 was inserviced by DON on 10/23/19 regarding timely nursing notes documentation relating any event or intervention that occurs or is noted. Licensed nursing staff have been reinserviced regarding timely documentation in the nursing progress note. 3. Any event or change in resident condition is reported immediately to the Sister Supervisor and DON/ADON, and is documented in a timely manner in the nursing progress notes. On a daily basis, the ADON or designee will review these notes for timeliness. Any finding will be documented with follow up and re- inservicing of responsible licensed nurse as necessary. 4. QA nurse will monitor compliance through weekly review of charts and ADON/designee's log. A summary report will be submitted at the quarterly QAPI meeting for discussion regarding improvement or possible need for further follow up. 5. Corrective action was completed on 12/02/19	12/02/19

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 _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 13 AM, she stated, "[Resident #10] did not have scratched on left side of face over the weekend it occurred on 10/21/19. During a face-to-face interview conducted on 10/24/19 at approximately 11:10 AM with Employee #5 who acknowledged the finding. He stated, "I am aware that [Resident #10] has a scratched on left side of her face, I cleansed it with normal saline and applied triple antibiotic to it but I did not document it." The facility staff failed to document that the resident had a scratched on the left side of her face.	F 842		