STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	10/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(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 An unannounced Quality Indicator Survey was conducted at Stoddard Baptist Nursing Home from October 23, 2017 through October 27, 2017. Survey activities consisted of a review of 40 resident clinical records during Stage 1; and review of 37 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews for 37 sampled residents. 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 g-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner	F 000	Please begin typing here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marcella D Johnson RN, LNHA	ADMINISTRATOR	12-1-17

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 L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services 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 POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - Interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, R/P- Responsible Party PO- By Mouth	F 000	F241 1. Employee #9 and 8 were immediately provided an in-service on resident's dignity, with emphasis on getting permission from the resident before entering a resident's room. 2. All other employees were observed for knocking and getting permission before entering a resident's room. There were no other employees observed doing the cited deficient practice. 3. The educator provided all other employees an in-service on resident dignity with emphasis on the importance of getting permission before entering a resident's room. 4. All staff will be monitored for knocking and waiting for resident response to enter a room and will be reported to QAPI quarterly. 5. Completion date 10/24/17	
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by:	F 241		

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F 241	Continued From page 2 Based on observation and staff interviews for one (1) of 37 Stage 2 sampled residents, the facility failed to promote the dignity of the resident by entering their room without first getting permission to do so. Findings included ... During a closed-door interview with Resident # 197 on October 24, 2017, at 09:50 AM, Employee #9, Certified Nurse Aide, knocked on the door and did not wait for permission from the resident before she entered the room. Approximately three minutes later, Employee #8, Registered Nurse, knocked on the door to the resident's room and entered before getting permission from the resident to do so. Employee #8 and Employee #9 acknowledged the findings at the time of the observation.	F 241		
F 272 SS=D	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 272		

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F 272	Continued From page 3 (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 37 Stage 2 sampled residents, the facility failed to accurately record one (1) resident's use of anticoagulant medication on the	F 272	F272 1. Resident #59's MDS was corrected and transmitted on 12/1/17 to reflect resident's use of anti-coagulant medication during the referenced dates of June 15-August 22, 2017. 2. All other records were reviewed for accuracy of MDS coding regarding anti-coagulant use and corrected as needed. There were no other MDS' found requiring correction. 3. The Director of Nursing provided in-service on accurate MDS coding to MDS coordinator on 12/1/17. 4. All residents on anti-coagulant will be reviewed for accuracy of coding monthly and reported to QAPI quarterly. 5. Completion date: 12/1/17	12/1/17 12/1/17

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F 272	Continued From page 4 annual Minimum Data Set (MDS). Resident # 59. Findings include... A physician's order dated June 14, 2017, directed, "Enoxaparin Sodium 40mg/0.4ml sub -Q (subcutaneous) daily for Deep Vein Thrombosis". A record review of the June, July, and August 2017, Medication Administration Record showed that Resident # 59 received Enoxaparin Sodium 40mg/0.4ml subcutaneous daily, June 15, 2017, to August 22, 2017. A review of the annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of August 15, 2017, showed that Section "N0410, Medications Received-anticoagulant" coded as "zero" indicated the resident did not receive this medication during the reference period. There was no evidence facility staff accurately coded the MDS for the resident's use of anticoagulant medication. Employee #10 and Employee #11, MDS Coordinators, acknowledged this finding.	F 272		
F 356 SS=D	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post	F 356		

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F 356	Continued From page 5 the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	1. The posted nurse staffing sheet for Unit 2 was immediately corrected to include the date; Unit 3's correct staffing sheet was immediately posted. 2. All other posted staffing sheets were checked for completeness and accuracy and replaced as needed. 3. All resident care coordinators and charge nurses were provided and in-service on the proper completion and posting of nurse staffing sheet on 10/23/17. 4. All posted nursing staffing sheets will be checked for accuracy and completeness and reported to QAPI quarterly. 5. Completion date 10/23/17	10/23/17 10/23/17

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F 356	Continued From page 6 (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to include the required data on the posted nurse staffing sheet on two (2) of three (3) units. Unit 2 and Unit 3. Findings included ... A. On 10/23/2017, at approximately 12:10 PM a tour of the facility, Unit 2 the posted nurse staffing sheet was observed not to include the date. A face-to-face interview conducted with Employee# 4 who stated, "I will correct it right now." Employee# 4 acknowledged the findings. B. On 10/23/2017, at approximately 12:30 PM a tour of the facility, Unit 3 reveals the posted nurse staffing sheet did not have the current date. The "Day Shift Unit 3 Charge Nurse and CNA Assignment" sheet was observed to have a date of "10/21/17." Employee # 5 states "the correct sheet is in the book we will post it now." Employee# 5 acknowledged the findings.	F 356		
F 386 SS=D	PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS CFR(s): 483.30(b)(1)-(3) (b) Physician Visits The physician must--	F 386		

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F 386	Continued From page 7 (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 37 Stage 2 sampled residents, it was determined the physician failed to evaluate the resident's condition to include Parkinson's disease and the appropriateness of the resident current medical regime [Carbidopa-Levodopa used to treat Parkinson's disease]. Findings included ... A review of the quarterly Minimum Data Set (MDS) assessment completed of May 29, 2017, revealed diagnoses that included Parkinson's disease. A review of the Physician's orders signed and dated June 2, 2017, directed the resident to receive Carbidopa-Levodopa 25-100 mg tablet every six (6) hours for Parkinson's disease and the diagnoses listed on the orders included Parkinson's disease. According to the Medication Administration records the resident	F 386	1. Resident #59's medical records were updated to include physician's evaluation of the total plan of care to include Parkinson's disease and use of Carbidopa-Levodopa 25-100 mg. 2. All other residents' records were reviewed for physician's review of total plan of care to include medication and treatment during each visit. There were no other records identified. 3. Physicians were provided in-service education on the needs to thoroughly review the resident's plan of care. 4. Physician evaluation of total plan of care will be monitored monthly and reported to QAPI quarterly 5. Completion date 12/1/17	12/1/17 11/27/17

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F 386	Continued From page 8 received Carbidopa-Levodopa 25-100 mg from April 4, 2016 through June 12, 2017. On June 12, 2017, Resident #59 was transferred to the hospital and readmitted to the facility on June 14, 2017. Review of the physician's notes showed the physician did not evaluated the resident's total plan of care to include Parkinson's disease and the resident's pre-hospitalization medication regime for the use of Carbidopa-Levodopa 25-100 mg. Upon readmission, a review of the Medication Administration Record from June 14 -30, July, August, September and October 2017, showed the resident was not receiving Carbidopa-Levodopa 25-100 mg tablet every 6 hours for Parkinson's disease. Further review of the physician's progress notes showed that the physician visited the resident on these dates: July 5, July 22, August 6, September 20, and October 4, 2017. During the aforementioned visits, there was no evidence the physician evaluated the resident's condition to include Parkinson's disease and use of Carbidopa-Levodopa 25-100 mg. During a face-to-face interview with Employee #12 on October 27, 2017, at 10:35AM he acknowledged the finding.	F 386		

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F 431	Continued From page 9	F 431	Finding #1 and 2	
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	1. All identified expired medical supplies and biologicals were immediately discarded. 2. All drugs and biological storage and compartments were checked for any expired items and discarded as appropriate. 3. All RCCs and licensed nurses were provided an in-service on checking expiration dates on medical supplies and biologicals and timely disposal of any expired items. 4. Resident Care Coordinators/ Designee will monitor storage compartments for expired biological and medical supplies weekly and report to QAPI quarterly. 5. Completion date 10/29/17	10/25/17 10/25/17 10/29/17

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F 431	Continued From page 10 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure that biologicals and medicals supplies were not available for use beyond the expiration date in two (2) of three (3) medication storage rooms. The findings include: 1.On October 25, 2017 at 11:17 AM the second floor medication storage area was toured with Employee # 13. The following medication supplies were stored for used past the expiration date. One (1) of one (1) 14 French catheter insertion tray (sterile) was open and stored for use. One (1) of one (1) bottle of sterile water 100 ml had an expiration date of July 2017. One (1) of one (1) case (48 100 ml bottles) of sterile water 100 ml had an expiration date of July 2017.	F 431		

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F 431	Continued From page 11 Employee # 13 acknowledged the findings at the time of the observations. 2.On October 25, 2017 at 11:17 AM the third floor medication storage area was toured with Employee # 14. The following medication supplies were stored past the expiration date. One (1) of one (1) CPR micro shield clear mouth barrier with a "use by" date of 1/2005 Two (2) of two (2) non-conductive connecting tubing latex free with an expiration date of 12/8/2015 One (1) of one box of Evencare glucose control solution with an expiration date of 8/2017 Employee # 14 acknowledged the findings at the time of the observations.	F 431		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (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 (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		

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F 514	Continued From page 12 (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. This REQUIREMENT is not met as evidenced by: Based on clinical chart review and staff interview for three (3) of 37 sampled residents facility staff failed to maintain clinical records in accordance with an accepted professional standard by failing to document a plan of care for abnormal lab values for (2) residents, and one (1) resident ' s refusal of a dietary supplement. Residents' # 163, #41 and Resident# 131. Findings included... 1. Facility staff failed to document a plan of care for abnormal lab results. A. On October 26, 2017, at approximately 12:00 PM a review of Resident lab report dated August 30, 2017, reveal a "Potassium result of 3.13" [normal range 3.5-5.5 mEq/L]. Resident# 163. A review of the Physician/Prescriber Response sheet dated September 10, 2017, indicate	F 514	Finding #1 A & B 1. Resident 163 and 41's medical records were amended by the nurse practitioner to reflect lab report on resident 163: Hemoglobin and Hematocrit on resident #41 2. The plan of care for other residents with abnormal lab values were reviewed. There were no other residents identified. 3. An in-service was provided by the Medical Director to the nurse practitioner on accuracy and completeness of documentation for abnormal labs. 4. Documentation for abnormal labs for residents will be monitored monthly and reported to QAPI quarterly. 5. Completed 12/1/17.	

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F 514	Continued From page 13	F 514		

"increase Potassium Chloride to 40 meq (milliequivalent) supplement, request Potassium level September 9/19/17".

A further review of the repeat lab data report dated September 19, 2017, reveals Potassium 3.15.

A review of a nurse's note with a date and time of September 19, 2017, at 3:24 PM state "lab results NP [nurse practitioner] reviewed potassium result-3.15, no new order". "Resident is on 40 Meq potassium daily."

On October 26, 2017, at approximately 12:30 PM a telephone interview conducted with Employee#3, Nurse Practitioner, who stated "I see a lot of residents, but in this case, the potassium level was not far off, but I should have written for a repeat lab, I see your point."

A further review of the clinical record reveals no documented harm to the Resident because of an untreated abnormal lab result.

Employee #3 acknowledged the findings.

B. On October 27, 2017, at approximately 9:30 AM a review of Resident lab report dated October 3, 2017, reveal Hemoglobin 8.9 [normal range 12.0-16.0 gram per deciliter], Hematocrit 27.0 [normal range 36.0-46.0]. Resident #41.

A review of nurses note dated October 4, 2017, reveal "S/P [status post] readmission adjusting well, lab results reviewed by NP and no new order given."

On October 27, 2017, at approximately 9:30 AM a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	10/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(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 514	Continued From page 14 face-to-face interview with Employee# 2 who stated: "yes a note that the lab results are the resident's baseline should have been written to take the guess out of it, I see what you mean, I will communicate this." A further review of the clinical record reveals no documented harm to the Resident because of an untreated abnormal lab result. Employee# 2 acknowledged the findings. 2. Facility staff failed to document refusal of a dietary supplement in the presence of weight loss. Findings included... A review of the Resident #131'sweight analysis log dates of April 2017 to October 2017 showed the following weights: April 2017 -147 pounds (lbs) May 2017- 145 lbs June 2017- 144 lbs July 2017 - 142 lbs August 2017-140 lbs September -138 lbs October - 136 lbs On October 26, 2017, at approximately 9:30 AM a face-to-face interview conducted with Resident# 131 who states "I may have lost 5 lbs, what is that, I am not stressed, I am eating, I feed my self and they give me enough to eat, I don't refuse any meals". A review of the Minimum Data Set [MDS] dated	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 15 August 9, 2017, showed diagnoses to include Heart Failure, Diabetes Mellitus Type 2, Hyperlipidemia and Hypertension. A further review of the clinical record showed Dietary Notes dated October 13, 2017, "Weight (lbs):136, weight continues to gradually trend downward-no significant weight loss, will continue to monitor PO [oral] intake and weight trends". A face-to-face interview conducted with Employee# 6 on October 26, 2017, at approximately 11:30 AM, "I documented the weight loss, but I did not document that the resident kept refusing the Glucerna." It would have been beneficial for the resident to have the Glucerna but there was no significant weight loss". "If the weight loss is significant this is more of a concern, I did not put that the resident refused the Glucerna in my notes and I did discuss this at the interdisciplinary team meeting". "You are right, I should have included this in my note." A further review of the clinical record reveals no documented harm to the Resident due to weight loss (11 lbs. over 7 months). Employee# 6 acknowledge the findings.	F 514	Finding #2 1. Resident 131's medical record was appended by the Dietician to reflect resident's refusal of Glucerna in the face of weight loss on 10/27/17. 2. All other residents on dietary supplements were reviewed for adequate and comprehensive documentation. There were no other similar findings. 3. In-service provided to the Dietician on the importance of complete and accurate documentation. 4. Dietary documentation will be monitored monthly and reported to QAPI quarterly. 5. Completion date 12/1/17.	10/27/17 11/29/17