Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD02-0019 | A. BUILDING: _____ B. WING _____ | R-C 01/25/2023 |

| 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) COMPLETE DATE |
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| {L 000} | Initial Comments<br><br>A Revisit Survey was conducted at this facility on January 23-25, 2023, as a follow up to the annual survey of November 9, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 91 and the survey sample included 22 residents.<br><br>After analysis of the findings, it was determined that the facility was not in compliance with 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities.<br><br>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:<br><br>AMS - Altered Mental Status<br>ARD - Assessment Reference Date<br>AV- Arteriovenous<br>BID - Twice- a-day<br>B/P - Blood Pressure<br>cm - Centimeters<br>CFR- Code of Federal Regulations<br>CMS - Centers for Medicare and Medicaid Services<br>CNA- Certified Nurse Aide<br>CRF - Community Residential Facility<br>CRNP- Certified Registered Nurse Practitioner<br>D.C. - District of Columbia<br>DCMR- District of Columbia Municipal Regulations<br>D/C - Discontinue<br>DI - Deciliter<br>DMH - Department of Mental Health<br>DOH - Department of Health<br>DON - Director of Nursing | {L 000} | Stoddard Baptist Nursing Home 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 officers, directors, employees or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State laws. | |

Health Regulation & Licensing Administration

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 2-9-23 |

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| {L 000} | Continued From page 1 | {L 000} | | |

ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD - Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2 - Oxygen
PA - Physician's Assistant
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO - by mouth
POA - Power of Attorney

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| {L 000} | Continued From page 2<br>POS - physician's order sheet<br>Prn - As needed<br>Pt - Patient<br>Q - Every<br>RD - Registered Dietitian<br>RN - Registered Nurse<br>ROM - Range of Motion<br>RP R/P - Responsibleparty<br>SBAR - Situation, Background, Assessment, Recommendation<br>SCC - Special Care Center<br>Sol - Solution<br>SW - Social Worker<br>TAR - Treatment Administration Record<br>Ug - Microgram | {L 000} | | |
| {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 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 | {L 051} | | |

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| {L 051} | Continued From page 3<br><br>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents.<br>This Statute is not met as evidenced by:<br>Based on record review and staff interview, for two (2) of 22 sampled residents, the charge nurse staff failed to update Resident #10's comprehensive care plan to include progression from a Stage 3 sacral pressure ulcer to an unstageable sacral pressure ulcer, upon the Resident's re-admission to the facility on 01/18/23; and failed to accurately document the location where Resident #7's blood pressure was being taken.<br><br>The findings included:<br><br>1.The charge nurse staff failed to update Resident #10's comprehensive care plan to include progression from a Stage 3 sacral pressure ulcer to an unstageable sacral pressure ulcer, upon the Resident's re-admission to the facility on 01/18/23<br><br>On 01/18/23 at 9:06 PM, the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following: "...re-admit from [Name of Local Hospital] with multiple diagnose including altered mental status, Stroke, Sepsis, UTI (Urinary Tract Infection). On assessment ...unstageable sacral ulcer measuring 7.5cm x 6.3cm with slough and eschar ...Orders given by MD: Cleanse sacral ulcer with Dakin's solution, pat dry, apply Santyl ointment, and cover with gauze two (2) times a day....."<br><br>Resident #10 was re-admitted to the facility on | {L 051} | #1<br><br>1. Resident #10 was reassessed and care plan was updated by the Director of Nursing on 1/25/23.<br>2. A review of residents returning from the hospital with pressure ulcers was conducted. There were no other residents identified.<br>3. A meeting was held by the DON on 2/1/23 with the licensed staff regarding the updating of care plan. The nursing supervisor will review new admissions records to ensure care plan is updated.<br>4. The nursing supervisor will review the care plans developed for residents with skin condition monthly and report to QAPI monthly.<br>5. Completion date 2/8/23<br>6. Director of Nursing | |

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| {L 051} | Continued From page 4<br>01/18/23 with the following diagnoses: Cerebral Infarction, Personal History of COVID-19, Pressure Ulcer Sacral Region, Stage 3, Colostomy Status, and Other Artificial Openings of Urinary Tract Status.<br><br>Review of Resident #10 medical record showed the following:<br><br>06/09/21[Care plan]: "Focus area: "[Resident #10] has a pressure ulcer to sacrum ...Goal: Resident's ulcer will heal without complications through the next 90 days. Approach: Keep clean and dry as possible...Apply dressings as ordered ... Assess the pressure ulcer for stage, size (length, width, and depth), presence/absence of granulation tissue, and epithelization... Weekly rounds by wound specialist ...Edited 10/19/22 ...Eval Notes ...Sacral ulcer stable. Tx (treat) as ordered. Seen by surgeon weekly." Of note, Resident #10's sacral pressure ulcer was not included in any other area on the Resident's comprehensive care plan.<br><br>10/12/22 [Quarterly Minimum Data Set] documented: Brief Interview for Mental Status Summary Score: "11" indicating the residents' cognition is moderately impaired, required extensive assistance for bed mobility, transfers, toilet use, dressing, and personal hygiene, and had one (1) Stage 3 pressure ulcer.<br><br>01/11/23 [Nursing Progress Note]: " ...while serving lunch at1pm resident was noted not responding to verbal communication ...MD (Medical Doctor) made aware of the above and ordered to send Resident to the nearest ER (Emergency Room) via 911 for further evaluation ..." | {L 051} | | |

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| {L 051} | Continued From page 5<br>01/18/23 at 8:05 PM [Nursing Progress Note]: " ... [Name of Resident #10] re-admitted from [Local Hospital] ... Skin is warm, dry to touch, multiple bruises to the bilateral upper extremity, red discoloration to bilateral heel, bilateral leg weakness, and an unstageable sacral pressure ulcer ..."<br><br>01/18/23 [Physician's Order]: "Cleanse sacral ulcer with Darkin's [Dakin's]solution, pat dry, apply Santyl ointment, and cover with dry gauze two (2) times a day."<br><br>01/18/23 [Physician's Order]: "Weekly skin assessment, once a day on Wednesdays 07:00 AM- 03:00 PM."<br><br>There was no evidence that facility staff updated the Resident's comprehensive care plan to address the care and treatment of the residents' unstageable sacral pressure ulcer that facility staff observed when she was re-admitted to the facility on 01/18/23.<br><br>During a face-to-face interview on 01/25/23 at 4:28 PM, Employee #2 acknowledged that Resident #10's comprehensive care plan had not been updated or revised to include the unstageable sacral ulcer that facility staff observed upon the Resident's re-admission to the facility on 01/18/23.<br><br>2.The charge nurse failed to accurately document the location where Resident #7's blood pressure was being taken.<br><br>Review of the facility's Plan of Corrections with a compliance date of 01/09/23 stipulated, "3. The Administrator provided an re-education on | {L 051} | #2<br><br>1. An assessment of Resident #7's left arm was done on 1/26/23. There were no negative findings on left arm. An order was obtained to address no blood pressure on left arm. The care plan was updated to reflect the order.<br>2 A review of residents on dialysis was conducted. There were no other residents impacted by this practice.<br>3. The nursing staff on units with dialysis residents were re-educated on the importance of documenting accurately where blood pressure was taken. Staff were advised that documentation errors may result in additional corrective actions.<br>4. The Director ofNursing/designee will review blood pressure documentation for residents on dialysis. The information will be reported to QAPI monthly.<br>5. Completion date: 2/8/23<br>6. Director of Nursing | |

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| {L 051} | Continued From page 6<br>accuracy of documentation..."<br><br>Resident #7 was admitted to the facility on 05/02/19 with diagnoses including Acute Kidney Failure, Pleural Effusion, Chronic Obstructive Pulmonary Disease, and Combined Systolic (congestive) and Diastolic (congestive) Heart Failure.<br><br>Review of Resident #7's medical record showed the following:<br><br>09/22/22 at 10:04 PM [Nursing Note] "[Resident #7] ... re-admitted from [Hospital Name] ... at 1:35 PM..."<br><br>09/22/22 [Physician's order] "Resident is for dialysis every Monday, Wednesday, and Friday."<br><br>A Significant Change MDS dated 09/27/22 showed facility staff coded: severe cognitive impairment and received dialysis while a resident.<br><br>10/27/22 at 7:10 AM [Nursing Note] "...Left for surgery appointment ... AV (arteriovenous) graft placement..."<br><br>10/27/22 at 11:34 PM [Nursing Note] "Resident wheeled back onto the unit at 7:10 PM...Left arm surgical site [new AV graft site] observed with transparent pressure dressing. No signs of bleeding noted..."<br><br>Review of Resident #7's vital signs showed that on the following dates and times, facility staff documented taking the Resident's blood pressure on the left arm:<br><br>01/14/23 at 3:47 AM<br>01/19/23 at 5:31 AM | {L 051} | | |

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| {L 051} | Continued From page 7<br>01/20/23 at 5:19 AM<br><br>A total of three (3) days, facility staff recorded obtaining Resident #7's blood pressure on the left arm.<br><br>During a face-to-face interview conducted on 01/25/23 at 11:30 AM, Employee #2 (Director of Nursing/DON) stated, "It's the night shift-the nurses know not to take the blood pressure in the arm with the dialysis site. They should not be documenting that they are taking any blood pressure on his left [arm]." | {L 051} | 1. The Drug Regimen Review for resident #8 was conducted. The LFT order was done on 1/24/23 and completed on 1/25/23 and results were documented.<br>2. A review of Drug Regimen Review was conducted. There were no other residents identified.<br>3. The process for addressing MMRs was revised on 2/3/23. The nursing supervisor will review the Drug Regimen Review folder on each unit. Any follow up action necessary will be initiated by the supervisor and the manager for the unit will ensure its completed.<br>4. The nursing manager will review the Drug Regimen Review folder daily and report results monthly to QAPI.<br>5. Completion date: 2/8/23<br>6. Director of Nursing | |
| {L 198} | 3231.9 Nursing Facilities<br><br>Each medical records shall serve as a basis for planning resident care and shall provide a means of communication between the physician and other employees involved in the residents' care.<br>This Statute is not met as evidenced by:<br>Based on record review and staff interviews, for one (1) of 22 residents, facility staff failed to take the action of ordering liver function tests for a resident in response to a monthly MRR (medication regimen review). Resident #8.<br><br>The findings included:<br><br>Facility staff failed to take the action of ordering liver function tests (LFTs) for Resident #8 in response to the monthly MRR (medication regimen review) with the Physician Prescriber Response of "Agree" dated and signed by the Physician on 01/18/2023.<br><br>Resident #8 was admitted to the facility on 01/13/22 with multiple diagnoses including | {L 198} | | |

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| {L 198} | Continued From page 8<br>Chronic Kidney Disease Stage 4, Urinary retention, a History of COVID-19 infection, and Dementia.<br><br>Review of Resident #8's medical record revealed the following:<br><br>A Quarterly Minimum Data Set (MDS) dated 11/03/22 showed facility staff coded: severely impaired cognitive response and as having Acute Kidney Failure and Chronic Kidney Disease Stage 4.<br><br>Care plan focus area "[Resident #8] is on nine (9) or more medications" last reviewed/revised on 11/10/22 had the following approach, "...Review medications at least monthly ...Monitor labs and report abnormal to Physician."<br><br>01/16/2023 at 7:04 PM [Pharmacist Note] "MRR completed. Recommendation check LFTs with next labs. Thank you."<br><br>Review of Resident #8's medical record and physical chart on 01/24/23 at 11:02 AM showed no documented evidence that facility staff had ordered the liver function tests (LFTs) for Resident #8.<br><br>During a face-to-face interview conducted on 01/24/23 at 2:20 PM, Employee #2 (Director of Nursing) reviewed the 01/16/23 [Pharmacist's Note] and acknowledged that there was no documented evidence of a physician's order for the Resident's liver function tests.<br><br>On 01/25/22 at approximately 4:30 PM, Employee #2 presented a copy of the following Physician's order: Other Test: (LFT) [DX (diagnosis): Chronic kidney disease, Stage 4 (severe)] once-one time; | {L 198} | | |

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| {L 198} | Continued From page 9<br>12:30 AM-08:30 AM."<br><br>{L 204} 3232.2 Nursing Facilities<br><br>A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following:<br><br>(a)The date, time, and description of the incident;<br><br>(b)The name of the witnesses;<br><br>(c) The statement of the victim;<br><br>(d) A statement indicating whether there is a pattern of occurrence; and<br><br>(e) A description of the corrective action taken.<br><br>This Statute is not met as evidenced by:<br>Based on record review and staff interview, for one (1) of 22 sampled residents, facility staff failed to conduct a thorough investigation that included statements from witnesses, and employees who worked when a resident fell from his wheelchair. In addition, the facility failed to forward the investigation results to the State Agency within five (5) working days of the incident. Resident #12.<br><br>The findings included:<br><br>Review of the facility's Plan of Corrections with a compliance date of 01/09/23 stipulated, stipulated, "3.The Administrator provided the Social Services staff, DON, Nursing Supervisors | {L 198}<br><br>{L 204} | 1. The DON met with Resident #12 on 1/30/23 who acknowledged that the incident on 1/14/23 was a fall. The charge nurse and the CNA providing care for resident on 1/14/23 provided a written statement. Unable to retrospectively send completed investigation within required 5-day window.<br>2. All complaint allegations were reviewed and there were no other allegations identified that would rise to the level of abuse or neglect.<br>3. The nursing supervisors were provided re-inservice on the process for completing an investigation including the process following the investigation and timely re-submission after follow up completed on 2/1/23.<br>4. Any resident complaint or reported incident of abuse will be monitored to ensure a thorough investigation is conducted with written statements from persons who may have knowledge of the event. Any findings from the audit conducted will be discussed monthly at QAPI meeting.<br>5. Completion date: 2/8/23<br>6. Director of Social Services | |

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| {L 204} | Continued From page 10<br>and Charge Nurses and in-service on the process for conducting an investigation of facility reported incidents, including abuse and elopement on 12/14/22. 4. Any resident complaint or reported incidents of abuse will be monitored to ensure a thorough investigation is conducted with written statements from persons who may have knowledge of event ...completion date: January 9, 2023."<br><br>On 01/15/23 at 12:03 AM, the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following: "Writer was called by the charge nurse to see [the] Resident who was sitting on [the] wheelchair but was observed sitting on the floor between his bed and his wheelchair. He is (was) alert and verbally responsive. He stated that he wanted to sit down on his bed, but he still sit (sat) down on the floor on (in) a sitting position ...no swelling, bruises or any injury was noted ..."<br><br>Resident #12 was admitted to the facility on 10/21/22 with diagnoses including malignant neoplasm of the prostate, Retention of urine, Difficulty in walking, and Cognitive communication deficit.<br><br>Review of Resident #12's medicalrecord revealed the following:<br><br>10/30/22 [Significant Change Minimum Data Set] documented: Brief Interview for Mental Status Summary Score: "08" indicating mildly impaired cognition, required extensive assistance for bed mobility, transfers, locomotion on the unit, toilet use, dressing, and personal hygiene, and uses a wheelchair for mobility. | {L 204} | | |

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| (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 204} | Continued From page 11<br><br>11/25/22 [Care Plan]: "Problem: [Resident #12] had a fall without injury. Goal(s): Resident's fall/injuries will be minimized ...Approach: Remind Resident to always call for assistance. Monitor when out of bed ..."<br>01/14/23 [Progress Note]: "Resident received OOB (out of bed) on w/c (wheelchair) in day area this shift ...Around 8:20 PM Resident call(ed) for help, noted on the floor in a sitting position beside his w/c, per resident, he slid out of his chair trying to transfer himself to bed. Writer educated Resident to use his call light when (in) need assistant (assistance), s/p (status post) fall, no apparent injury noted ...denied any pain ...Neuro checks in progress ..."<br><br>01/14/23 [Care Plan]: "Problem: [Resident #12] had a fall without injury related to failure to call for assistance during transfer ...Goal(s): Resident's fall/injuries will be minimized ...Approach: Hourly monitor for falls ..."<br><br>01/16/23 [Investigation Report Form] documented: " ...Incident witnessed by: unwitnessed ...Type of Incident: ...Fall ...Resident Injured: "No" ...Location of Incident: Resident Room ...Statements: Summary of Resident's statements: Stated he wanted to sit on his bed but sat on the floor ...<br><br>Under the Section of the form with the heading, "List of Staff working in the area at the time of the incident" were the following: [Licensed Practical Nurse (LPN), assigned to Resident #12, [Certified Nurse Aide(CNA) assigned to Resident #7] and [Second CNA working on the unit when the incident occurred] ...<br><br>The following written statements from two (2) facility staff were attached to the form: | {L 204} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD02-0019 | A. BUILDING: _____ B. WING _____ | R-C 01/25/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| {L 204} | Continued From page 12<br><br>01/14/23 [Statement from CNA assigned to Resident #12] that read: 'Dear Sir/Ma, I was called by the Charge Nurse that the resident slide (slid) down from his wheelchair.'<br><br>01/25/23- Last day of the State Agency survey [Statement from Administrator] that read: 'Resident sustained a fall without injury. No indication of abuse (was) noted. Statements obtained from staff care plan (were) updated .... ' Of note, there were no written statements from the second CNA working on the unit when the incident occurred, and the Charge Nurse assigned to Resident #12.<br><br>In the last section of the facility's Investigative Report Form, under the heading, 'Signatures of person completing the investigation,' were the following facility staff signatures: Director of Nursing, Human Resources Staff, Director of Quality Improvement, Director of Staff Development, and the Administrator. Next to all the signatures was a date entry of 01/25/23. Of note, this was 11 working days after Resident #12's fall on 01/14/23.<br><br>A review of Resident #12's medical record and review of the facility's investigation documents lacked documented evidence that the facility conducted a thorough investigation for the Resident's fall on 01/14/23 by failing to obtain written statements from the Charge Nurse, and the second CNA working on the unit when the incident occurred.<br><br>In addition, the facility failed to provide its findings of the investigation for Resident #12's fall within five (5) working days of the incident to the State Agency. The Administrator's written statement, | {L 204} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD02-0019 | A. BUILDING: _____ B. WING _____ | R-C 01/25/2023 |

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| {L 204} | Continued From page 13<br>the facility employees' signatures, and date entries show documented evidence that the facility completed its investigation and provided its findings to the State Agency surveyors on 01/25/23, 11 working days after the incident.<br><br>On 01/25/23 at approximately 6:00 PM, Employee #1 (Administrator) and Employee #2 (Director of Nursing) acknowledged the findings and made no further comment. | {L 204} | | |