PRINTED: 12/30/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI Á. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		095020	B. WING _		C 11/09/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11103/2022
STODDA	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW WASHINGTON, DC 20010	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	L	PROVIDER'S PLAN OF CORRECTION	T ag
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		
E 000	Initial Comments		E 0	00	
E 004 SS=F	An Emergency Prepare conducted November of Health, Health Reg Administration, in accidude 494.62. The survey for in substantial compliar Preparedness required Medicaid Participating 42 CFR 494.62. The CDevelop EP Plan, Rec CFR(s): 483.73(a) §403.748(a), §416.54 §441.184(a), §460.84 §441.184(a), §460.84 §485.542(a), §485.62 §485.920(a), §486.36 §494.62(a). The [facility] must comprederal, State and local preparedness required develop establish and emergency preparedness program limited to, the following (a) Emergency Plan. Tand maintain an emergency Plan. Tand Plan Plan Plan Plan Plan Plan Plan Plan	pund that the facility was not since with Emergency ements for Medicare and providers and Suppliers, census was 101. View and Update Annually (a), §418.113(a), (a), §482.15(a), §483.73(a), 2(a), §485.68(a), 5(a), §485.727(a), 0(a), §491.12(a), Apply with all applicable cal emergency ments. The [facility] must maintain a comprehensive less program that meets the ection. The emergency must include, but not be g elements: The [facility] must develop gency preparedness plan the distribution of the gency preparedness plan the gen	E 00	Stoddard Baptist Nursing Homakes its best effort to ope in substantial compliance both Federal and State La Submission of this Plan Correction (POC) does constitute an admission agreement by any party, officers, directors, employees	orate with aws. of not or its s or ruth idity the This is
	following: * [For hospitals at §48; 8485 625(a):] Emerges				
	CAH] must comply with	ncy Plan. The [hospital or h all applicable Federal,			
(BUKATORY DI	KECTOR'S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
			A. BOILDI	.,0_			С
		095020	B. WING_			11	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H SUMMARY STA	OME ATEMENT OF DEFICIENCIES	ID.	1	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
E 007	State, and local emery requirements. The [ho develop and maintain emergency prepared requirements of this sall-hazards approach. * [For LTC Facilities at Plan. The LTC facility an emergency prepare reviewed, and update. * [For ESRD Facilities Plan. The ESRD facility maintain an emergency must be [evaluated], a years. This REQUIREMENT by: Based on record reviestaff failed to maintain preparedness plan. The findings included: On November 2, 2022 emergency preparedness included: On November 2, 2022 emergency preparedness included: Un November 2, 2022 emergency preparedness included: During a face-to-face 2022, at approximately	gency preparedness pspital or CAH] must a comprehensive less program that meets the ection, utilizing an It §483.73(a):] Emergency must develop and maintain edness plan that must be d at least annually. at §494.62(a):] Emergency ty must develop and by preparedness plan that and updated at least every 2 is not met as evidenced ew and interview, facility an updated emergency , review of the facility's ess plan, showed the its plan within the required m of one (1) year. The its January 2020. interview on November 3, 11:00 AM, Employee #1 inowledged the findings.	E 00	004	 The emergency preparedness plan was reviewed and updated at needed and dated to reflect review and/or revision date. All other emergency preparedness plans were reviewed and updated as needed. The Emergency Preparedness Team was provided an in service or the need to review the emergency preparedness plan on an annual basis. The emergency preparedness plan on an annual basis. The emergency preparedness plan will be reviewed monthly, revise and updated as appropriate, and current status reported to QAPI Completion date: January 9, 2023 Maintenance Director 		
SS=F	CFR(s): 483.73(a)(3)						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		STRUCTION			SURVEY PLETED
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		095020	B. WING				l	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		1818 N	FADDRESS, CITY, STATE, ZIP CO EWTON ST. NW INGTON, DC 20010	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
	§441.184(a)(3), §460 §483.73(a)(3), §483.4 §485.68(a)(3), §485.5 §485.727(a)(3), §485.5 §485.727(a)(3). [(a) Emergency Plan. and maintain an emer that must be reviewed 2 years. The plan must (3) Address [patient/cl but not limited to, person services the [facility] han emergency; and coincluding delegations plans.** *[For LTC facilities at a Plan. The LTC facility an emergency prepare reviewed, and updated plan must do all of the (3) Address resident plimited to, persons at-LTC facility has the ab emergency; and continuiting delegations of plans. *NOTE: ["Persons at rihospice, PACE, HHA, RHC/FQHC, or ESRD]	54(a)(3), §418.113(a)(3), 0.84(a)(3), §482.15(a)(3), 475(a)(3), §484.102(a)(3), 42(a)(3), §485.625(a)(3), 920(a)(3), §491.12(a)(3), The [facility] must develop regency preparedness plan it, and updated at least every st do the following:] Ilient] population, including, sons at-risk; the type of least the ability to provide in portinuity of operations, of authority and succession §483.73(a):] Emergency must develop and maintain redness plan that must be died at least annually. The following: opulation, including, but not isk; the type of services the ility to provide in annuity of operations, of authority and succession isk" does not apply to: ASC, CORF, CMCH, facilities.] is not met as evidenced as we and staff interview,	E	007	 The resident population was immediately as for unique resi vulnerabilities documented in emergency preparedness There were no emergency preparedness be reviewed an updated. The Emergency Preparedness was provided vin-service on the to have an updassessment of specific vulnera on 11/11/22. The emergency preparedness was provided vin-service on the to have an updassessment of specific resider preparedness pereviewed for specific resider population assess and reported to monthly. Completion data January 9, 202 MDS Director 	ssessed ident and the plan. o other plans to nd plan will it is plan will be an expected with the will be an expected will be an expected will be an expected will		

	F CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		095020	B. WING				C
	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 318 NEWTON ST. NW VASHINGTON, DC 20010	11	/09/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	population to address emergency. The findings included: On November 2, 2022 emergency prepared facility did not have do identify its specific resunique vulnerability in or disaster. Document during the survey did resident population not buring a face-to-face 2022, at approximately and Employee #7 acki INITIAL COMMENTS An unannounced Reconducted at Stoddard from October 31, 2022 Survey activities consirecord reviews, and rethe facility's census did and the survey sample. The following complain this survey: DC0001010 DC00010861 and DC0010213, DC00010213, DC00010213, DC00010213, DC00010213, DC00010213.	their specific needs in an	FO	000			
	DC00010213, DC0001 DC00010331, DC0001 DC00010467, DC0001 DC00010700, DC0001 DC00010795, DC0001	0341, DC00010434, 0470, DC00010657, 0726, DC00010763,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY PLETED
			A. BOILDI	ING			С
		095020	B. WING				/09/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	J	
0700045	D DARTICT MURCING H	OME			1818 NEWTON ST. NW		
STODDAR	RD BAPTIST NURSING H	OME		,	WASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
		·			DEFICIENCY)		
						•	
F 000	Continued From page	· 4	F (000			
	DC00011161 and DC	00011139.					
	Federal and Local det	ficiencies were cited related					
	to the investigation of:						
	DC00011017, DC000						
	DC00010331, DC000						
	DC00010470, DC000						
	DC00010795, and DC	00011161.					
	After analysis of the fi	ndings, it was determined					
		ot in compliance with the					
	requirements of 42 CF	R Part 483, Subpart B, and					
	Requirements for Long	g Term Care Facilities					
	During the survey act	ual harm level deficiencies					
	were identified at: F 68						
	The following is a direct						
	and/or acronyms that report:	may be utilized in the					
	тероп.						
ľ	AMS - Altered Mental	Status					
	ARD - Assessment Re	eference Date					
	AV- Arteriovenous						
	BID - Twice- a-day B/P - Blood Pressure						
I	cm - Centimeters						
	CFR- Code of Federal	Regulations					
	CMS - Centers for Med						
	Services						
	CNA- Certified Nurse /						
	CRF - Community Res	idential Facility tered Nurse Practitioner					
	D.C District of Colum						
- 1	DCMR- District of Colu						
	Regulations	·					
	D/C - Discontinue						
	DI - Deciliter						
	DMH - Department of I	Mental Health					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY IPLETED
			=				С
		095020	B. WING			11	1/09/2022
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	·	.,
					1818 NEWTON ST. NW		
STODDAR	RD BAPTIST NURSING H	OME		١	WASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFI:		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
F 000	Continued From page	: 5	F (000			
	DOH - Department of	Health					
	DON - Director of Nur	•					
	ED - Emergency Depart						
	EKG - 12 lead Electro						
	EMS - Emergency Me	` ,					
	ER - Emergency Roor	m ·					
	F - Fahrenheit						
	FR French	in aid and					
	FRI - Facility reported G-tube - Gastrostomy						
	HR - Human Resource						
	Hrs - Hours	55					1
	HS - hour of sleep						
	HSC - Health Service	Center					
	HVAC - Heating ventil						
	ID - Intellectual disabil						
	IDT - Interdisciplinary						
		ntion and Control Program					
	LPN - Licensed Practic	cal Nurse					
	L - Liter						
	Lbs - Pounds (unit of n	•					
1	MAR - Medication Adn MD - Medical Doctor	ninistration Record					
	MDS - Minimum Data	Sat					
i i	Mg - milligrams (metric						
1	M - Minute	system and or massy					
		system measure of volume)					
	Mg/dl - milligrams per						
	Mm/Hg - millimeters of						
	MN - midnight						
l l	N/C - nasal cannula						
	Neuro - Neurological						
1	NFPA - National Fire P						
	NP - Nurse Practitione	r					
	O2 - Oxygen						·
	PA - Physician's Assist						
	PASRR - Preadmissior Review	i screen and kesident					
1		us Endoscopio					
	Peg tube - Percutaneo	us Endoscopic					

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		095020	B. WING				C
	ME OF PROVIDER OR SUPPLIER DDDARD BAPTIST NURSING HOME			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010	11	/09/2022
	ACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Gastroste PO - by r POA - Po POS - ph Prn - As i Pt - Patie Q - Every RD - Reg RN - Reg ROM - Ri RP R/P - SBAR - S Recomm SCC - Sp Sol - Solu SW - Soo TAR - Tre Ug - Micro Resident CFR(s): 4 §483.10(a The resid self-deter access to outside th this section §483.10(a with respe resident ir promotes her quality individuali promote ti	mouth ower of Attorn nysician's ord needed ent y gistered Dieti gistered Nurs ange of Motic Responsible Situation, Bac endation oecial Care C ution cial Worker eatment Adm ogram Rights/Exerc 483.10(a)(1)(a) Resident F lent has a rig mination, and opersons and e facility, income on. a)(1) A facility ect and dignit on a manner a maintenance y of life, reco- ity. The facility he rights of the a)(2) The facility a)(2) The facility	tian e on eparty ckground, Assessment, enter inistration Record cise of Rights 2)(b)(1)(2) Rights. ht to a dignified existence, d communication with and d services inside and cluding those specified in y must treat each resident ty and care for each and in an environment that e or enhancement of his or gnizing each resident's ty must protect and		550			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		SURVEY PLETED
		095020	B. WING _		1	C /09/2022
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010 PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	CTION DULD BE	(X5) COMPLETION DATE
F 550	severity of condition, must establish and m practices regarding traprovision of services of residents regardless of \$483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit \$483.10(b)(1) The fact resident can exercise interference, coercion from the facility. \$483.10(b)(2) The resident can exercise interference, coercion from the facility. \$483.10(b)(2) The resident can exercise of interference, coreprisal from the facilit rights and to be supposed exercise of his or her rights and to be supposed exercise of his or her rights. This REQUIREMENT by: Based on observation interview, for one (1) of facility staff failed to en and privacy as evident privacy cover over the bag. Resident #298. The findings included: During a facility tour coapproximately 3:15 PM	or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. Fight to exercise his or her the facility and as a citizen ed States. Illity must ensure that the his or her rights without, discrimination, or reprisal ident has the right to be percion, discrimination, and y in exercising his or her orted by the facility in the lights as required under this is not met as evidenced of the sampled residents, asure a resident's dignity bed by failing to place a resident's urine collection onducted on 10/31/22 at 1, Resident #298 was with her urine collection to visitors and other	F 5	Resident #298 1. The CNA assigned to F #298 covered the resid catheter collection bag as CNA was made awa bag was not covered. F has since been dischar no other corrective actid done during this time. 2. There were 4 other resilvith foley catheter collection cover and were not affer this deficient practice. 3. The Nurse Educator procedures and other facility personnel involved in confoley catheter collection in-service education on proper procedures to endignity on 10/31/22. 4. The Director of Nursing designee will conduct raweekly observation of rewith foley catheters to endignity on the conduct raweekly observation of rewith foley catheters to endignee will conduct raweekly observation of rewith foley catheters to endignee the collection covered. Observation reduced by QAPI Comonthly and will continue monitored until 3 month consistent 100% compliates achieved. 5. Corrective action compliates January 9, 2023 6. Nurse Educator	ent's foley as soon are that Resident ged and on can be idents ection ave a n bag ected by ovided the overing bags on the asure for andom esidents ensure bags are eports will ommittee ue to be s of ance has	

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY IPLETED
		095020	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	095020	B. WING	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	11	/09/2022
STODDA	RD BAPTIST NURSING H	OME		18	118 NEWTON ST. NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Resident #298 was an 10/28/22 with multiple Overactive Bladder and A review of the medic following: 10/28/22 [Nursing Prof#298]newly admittedCatheter was placed Resident however fail was replaced and is to	dmitted to the facility on a diagnoses that included and Change in Bowel Habit. al record revealed the agrees Note] "[Resident diffrom [Hospital name]	F	550			
SS=E	indwelling Foley inserturinary retention" During a face-to-face in 10/31/22 at approxima #17 (Licensed Practica acknowledged the find comment. Cross reference DCMI Request/Refuse/Dscm CFR(s): 483.10(c)(6)(8) §483.10(c)(6) The right discontinue treatment, to participate in experiformulate an advance §483.10(c)(8) Nothing construed as the right	R 3269.1d tnue Trmnt;FormIte Adv Dir B)(g)(12)(i)-(v) It to request, refuse, and/or to participate in or refuse mental research, and to directive. in this paragraph should be of the resident to receive al treatment or medical	F 5	78			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVIDENTIFICATION NUMBER: A. BUILDING COMPLETE					
		095020	B. WING				C
		093020	D. WING -			11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAR	RD BAPTIST NURSING H	OME		1	1818 NEWTON ST. NW		
OTOBBAI				١	WASHINGTON, DC 20010		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	5/1/2
					<u>'</u>		
F 578	Continued From page			57 0			
1 370	Continued From page	: 9	F:	578			
	8483 10(a)(12) The fa	cility must comply with the					
	requirements specifie						
	subpart I (Advance Di						
		s include provisions to					
		itten information to all adult					
•		the right to accept orrefuse					
	medical or surgical tre						
	•	ulate an advance directive.					
	(ii) This includes a wri						
	• •	olement advance directives					
	and applicable State Is						
	(iii) Facilities are perm	itted to contract with other					
	entities to furnish this	information but are still					
	legally responsible for	ensuring that the					
	requirements of this se	ection are met.					
1	(iv) If an adult individu	al is incapacitated at the					
	time of admission and						
		te whether or not he or she					
		nce directive, the facility					
		ective information to the					
		presentative in accordance					
	with State law.						
		elieved of its obligation to					
1	•	n to the individual once he					
	or she is able to receiv	must be in place to provide					
1	• •	ndividual directly at the					
	appropriate time.	ndividual directly at the					
		is not met as evidenced					
	by:						
		w and staff interviews, for		ļ			
	four (4) of 41 sampled						
	failed to determine who						İ
1		AD) and failed to provide					
	residents or their repre						
	•	AD. Residents' #55, #67,				ĺ	1
į.	#69 and #248.	•					
			_1				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		095020	B. WING			1.	C 1/09/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1	110312022
					B18 NEWTON ST. NW		
STODDAF	RD BAPTIST NURSING H	OME			ASHINGTON, DC 20010		
(X4) ID	l .	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	-	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 578	· · · · · · · · · · · · · · · · ·		F	578	F578: Advance Directive – Reside #55, 67, 69 and 248	ents	
	The findings included	:					
					Copies of the Advance		
		o provide documented			Directive Status forms we		
	evidence that Resider				placed in the resident #55 and 69 medical records.	0, 67,	
	directives or were give formulate or refuse ar			1	Residents #55,67, and 69	.	
	Tormulate or relade ar	radvanced directive.			were provided information		
	Resident #55 was adr	mitted to the facility on			advance directive upon	. 011	
		es that included: Presence			admission. Resident #248	3 has	
		loint, Pressure Ulcer of			been discharged.		
	Right Heel, Hypothyro	oidism, and Tachycardia.					
		ueen i			The Admissions Director		
		#55's electronic record			conducted a chart audit o		
	revealed:				residents for information of	on	
	A Quarterly Minimum	Data set (MDS) dated			Advance Directives from	ad	
	09/01/22 documented				12/13/22. Residents in ne of information on Advance		
	moderately impaired of				Directive were provided	7	
	, , , , , , , , , , , , , , , , , , , ,				information and Advance		
	Review of Resident #5	55's physical record			Directive Status form place	ed	
	revealed:				on the resident's medical		
					records (chart). No resid	ents	
	A green colored piece	of paper read: "Full Code"			were adversely affected b	у	
		- '			this deficient practice.		
	Face sheet that listed	-					
	Resident #55's emerg	ency contact.			3. The Nurse Educator provi		
	Under the "Legal Dog	ıments" tab, a clear, empty,			in-service education to the		
		Advanced Directive" was	Í		social services staff, licen- nurses, and admissions s		
	observed.				regarding the documentat		
					procedures for Advance		
	There was no docume				Directives and where to lo	cate	
		Advanced Directive or that			them in the resident's cha		
	facility staff offered the				and electronic medical red	cord	
		ortunity to formulate or			on 12/14/22.		
	refuse Advanced Direc	cuves.					
	2. Facility staff failed to	provide documented					

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW MASHINOTON, DC 2010 PREFIX TAG CONTINUED TO THE APPROPRIATE OF DEPOLINCIES TAG F 578 Continued From page 11 evidence that Resident #57 had advanced directives or were given the opportunity to formulate or refuse an advanced directive. Resident #67 was admitted to the facility on 11/08/21 with diagnoses including Dementia, Psychotic Disturbance, Anxiety, Cerebral Vascular Accident, and Generalized Muscle Weakness. A review of Resident #67's electronic record revealed: A Quarterly Minimum Data set (MDS) dated 03/15/22 documented that the Resident had 3 Brief Interview for Mental Status (SIMS) summary score of "10," indicating moderately impaired cognition. Review of Resident #68's physical record revealed: A green colored piece of paper read: "Full Code". Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident #68 had advanced Directive or refuse Advanced Directive to that facility staff failed to provide documented evidence that Resident #68 had advanced Directives.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME SIRMARY STATEMENT OF DEPICIENCIES BIAMARY STATEMENT OF DEPICIENCIES SIRMARY STATEMENT OF DEPICIENCIES BIAMARY STATEMENT OF DEPICIENCIES BIAMARY STATEMENT OF DEPICIENCIES SIRMARY STATEMENT OF DEPICIENCIES BIAMARY STATEMENT OF DEPICIENCIES CECAPOLA COMMENTION PRESIX F578 CONTINUED From page 11 evidence that Resident #67 had advanced directive or vere given the opportunity to formulate or refuse an advanced directive. Resident #67 was admitted to the facility on 11/08/21 with diagnoses including Dementia, Psychotic Disturbance, Anxiety, Cerebral Vascular Accident, and Generalized Muscle Weakness. A review of Resident #67's electronic record revealed: A quarterly Minimum Data set (MDS) dated 09/15/22 documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of "10," indicating moderately impaired cognition. Review of Resident #68's physical record revealed: A green colored piece of paper read: "Full Code". Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident or their representative the opportunity to formulate or refuse Advanced Directives. 3. Facility staff failed to provide documented evidence that Resident #68 had an Advanced Directives.				7 5012511				С
STODDARD BAPTIST NURSING HOME 1816 NEWTON ST. NW WASHINGTON, DC 20010			095020	B. WING _				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 11 evidence that Resident #67 had advanced directives or were given the opportunity to formulate or refuse an advanced directive. Resident #67 was admitted to the facility on 11/08/21 with diagnoses including Dementa, Psychotic Disturbance, Anxiety, Cerebral Vascular Accident, and Generalized Muscle Weakness. A review of Resident #67's electronic record revealed: A Quarterly Minimum Data set (MDS) dated Og/15/22 documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of "10," indicating moderately impaired cognition. Review of Resident #68's physical record revealed: A green colored piece of paper read: "Full Code". Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident #88 had an Advanced Directive or that facility staff foffered the resident or their representative the opportunity to formulate or refuse Advanced Directives.	NAME OF P	ROVIDER OR SUPPLIER						
SUMMANY STATEMENT OF DEPRICENCES PRESS PROVIDED STANK PRESSON PRES	STODDAF	RD BAPTIST NURSING H	OME					
FREINT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 11 evidence that Resident #87 had advanced directives or were given the opportunity to formulate or refuse an advanced directive. Resident #67 was admitted to the facility on 11/08/21 with diagnoses including Dementia, Psychotic Distributance, Anxiety, Cerebral Vascular Accident, and Generalized Muscle Weakness. A review of Resident #67's electronic record revealed: A Quarterly Minimum Data set (MDS) dated 09/15/22 documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of "10," indicating moderately impaired cognition. Review of Resident #68's physical record revealed: A green colored piece of paper read: "Full Code". Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident #88 had an Advanced Directive or that facility staff failed to provide documented evidence that Resident #89 had advanced 3. Facility staff failed to provide documented evidence that Resident #89 had advanced								T
F 578 Continued From page 11 evidence that Resident #67 had advanced directives or were given the opportunity to formulate or refuse an advanced directive. Resident #67 was admitted to the facility on 11/08/21 with diagnoses including Dementia, Psychotic Disturbance, Anxiety, Cerebral Vascular Accident, and Generalized Muscle Weakness. A review of Resident #67's electronic record revealed: A Quarterly Minimum Data set (MDS) dated 09/15/22 documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of *10,* indicating moderately impaired cognition. Review of Resident #68's physical record revealed: A green colored piece of paper read: "Full Code". Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident #58 had an Advanced Directive or that facility staff failed to provide documented evidence that Resident #59 had advanced 67, 69 and 248 - continued 4. Social Service Director/ designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for documentation of the resident's Advanced Directive or was observed. 5. Completion date: 1-9-23 6. Social Service Director	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
directives or were given the opportunity to		evidence that Resident directives or were give formulate or refuse and Resident #67 was add 11/08/21 with diagnost Psychotic Disturbance Vascular Accident, and Weakness. A review of Resident #67 revealed: A Quarterly Minimum 09/15/22 documented Brief Interview for Merscore of "10," indicating cognition. Review of Resident #67 revealed: A green colored piece Under the "Legal Docuplastic cover labeled "Accident #68 had an Afacility staff offered the representative the oppose refuse Advanced Direct 13. Facility staff failed to evidence that Resident #68 had an Afacility staff offered the representative the oppose of the refuse Advanced Direct 13. Facility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff offered the representative the oppose of the prefuse Advanced Direct 13. Facility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence that Resident #68 had an Afacility staff failed to evidence #68 had an Afacility staff failed to evidence #68 had an Afacility staff failed to evidence #68 had an Afacility staff failed #68 had an A	ant #67 had advanced en the opportunity to advanced directive. mitted to the facility on ses including Dementia, e., Anxiety, Cerebral did Generalized Muscle #67's electronic record Data set (MDS) dated that the Resident had a natal Status (BIMS) summary ag moderately impaired #8's physical record of paper read: "Full Code". Juments" tab, a clear, empty, Advanced Directive" was Inted evidence that Advanced Directive or that exercise resident or their ortunity to formulate or entitives.	F 5	578	4. Social Service Director/ designee will perform weekly medical record audits of new admissions and those residents on th MDS assessment schedu for documentation of the resident's Advance Directive/code status. Results of the audits will reported to QAPI monthly and will be monitored unt 100% compliance is maintained for 3 months. 5. Completion date: 1-9-23	s ne ule be	

AND DIAM OF CORRECTION IDENTIFICATION NI IMPED		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		095020	B. WING			11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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OTOBBAI	AD BAI TIOT NOTCHIOTI			١	WASHINGTON, DC 20010		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 578	Continued From page	e 12	F (578			
	Resident #69 was add	mitted to the facility on					
	06/14/22 with diagnos	ses including Parkinson's					
	Disease, Hereditary a	and Idiopathic Neuropathy.					
	Review of Resident #6	69's electronic record					
	revealed:						
	<u>-</u>	Data set (MDS) dated					
	06/20/22 documented	I that the Resident had a					
	Brief Interview for Mer	ntal Status (BIMS) summary					
	score of "10," indicatir	ng moderately impaired					
	cognition.						
	Review of Resident #6	69's physical record					
	revealed:						
	A green colored piece	of paper read: "Full Code".					
		uments" tab, a clear, empty,					
	•	Advanced Directive" was					
	observed.						
	-						
1	There was no docume						
i i		Advanced Directive or that					
- 1	facility staff offered the						
		portunity to formulate or					
	refuse Advanced Direc	ctives.					
	Duning a face to feet			ļ			
		nterview on 11/03/22 at					
		3 (Acting Director of Social					
	Work) stated that if the		1				
		should be in the resident's					
	medical chart behind to	ne code sheet.					
	Ouena veference DOM	3 2224 42					
	Cross reference DCMF	₹ 3231.12					
	4 English staff failed to	determine whether					
	4. Facility staff failed to	Advanced Directives (AD)					
	Resident #240 nad an	Auvanceu Directives (AD)					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		095020	B. WING			C 11/09/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1818 NEWTON ST. NW WASHINGTON, DC 20010	IP CODE	1110912022	
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F 578	and failed to offer the formulate or refuse Ar Resident #248 was an 10/19/22 with multiple Sepsis, Urinary Tract Prostatic Hyperplasia Review of Resident #revealed the following 10/20/22 at 12:12 PM "Initial Note [Reside [Facility Name] is a verbally responsive anursing and rehab (redischarge to home." Care plan focus area Advance Directive (All resident/family wishes showed the approach reviewed with residen and PRN (as needed) An Admission MDS defacility staff coded: mocognition. Review of Resident #2 documented evidence determined whether the failed to offer the residented and AD. During a face-to-face in 1/03/22 at 9:23 AM, Editorial Editoria Editorial Editori	resident the right to dvanced Directives. dmitted to the facility on a diagnoses that included: Infection (UTI) and Benign (BPH). 248's medical record [Social Services Note] Int #248] admitted to lert, oriented x 3 and admitted for short-term skill habilitation) services and [Resident #248] has D), full code r/t (related to) I last revised on 10/22/22 I "Advance Directive will be but family q (every) 3 months I ated 10/23/22 showed aderately impaired 248's medical record lacked that facility staff ler resident had AD and lent the right to formulate or employee #8 stated, "I have sident #248) Advanced	F	578			

	F CORRECTION	IDENTIFICATION NUMBER:	` ′		= CONSTRUCTION		E SURVEY IPLETED
		007000	B 100NC				С
NAME OF P	ROVIDER OR SUPPLIER	095020	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11	/09/2022
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F 578	Continued From page	: 14	F:	578			
F 607 SS=D	Cross reference DCM Develop/Implement A CFR(s): 483.12(b)(1)-	buse/Neglect Policies	F	507			
	§483.12(b) The facility implement written poli	must develop and cies and procedures that:					
	§483.12(b)(1) Prohibit neglect, and exploitati misappropriation of re	on of residents and					
	§483.12(b)(2) Establis to investigate any such	sh policies and procedures h allegations, and					
	§483.12(b)(3) Include paragraph §483.95,	training as required at					
	§483.12(b)(4) Establis QAPI program require	h coordination with the d under §483.75.	.				
		unded long-term care with section 1150B of the procedures must include					
		ng a conspicuous notice of fined at section 1150B(d)					
	(2) of the Act. This REQUIREMENT i by:	at section 1150B(d)(1) and is not met as evidenced we and staff interview, for					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		095020	B. WING _			11/09/2022	
	PROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010				
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F 607	failed to implement its investigations of facility evidenced by failure to investigation of: one readuse; and one reside allegation of abuse, at #4 and #82. The findings included Review of the policy of Resident Abuse, Grie revised 09/20/21 doct abuse will be investigation give in which was a means willful unreasonable confine punishment with resulty mental anguish Neg provide goods and see physical harm, mental Investigate different identify the staff memory of the investigation of Resident Pacific Staff failed to evidenced by failure to investigation of Reside (being handled roughly Resident #4 was admit Resident #4 was admit should be investigated to the staff failed to evidenced by failure to investigation of Reside (being handled roughly Resident #4 was admit Resident #4 was admit should be investigated to the staff failed to evidence with the staff failed to evid	s policies for conducting ty reported incidents as o conduct a thorough esident's allegation of ent's unwitnessed fall, and elopement. Residents' entitled, "Social Service vance and Complaints" unmented, " All suspected ated, with a report of such writing to the Administrator" Is policy titled "Prohibition of e Prevention" with s /22, revealed the following, all infliction of injury, ment, intimidation, or ting physical harm, pain or lect means failure to roices necessary to avoid anguish, or mental illness types of incidents, and per responsible for the initial the proper esources will complete a on" o implement its policy as o conduct a thorough ent #4's allegation of abuse y by staff).	F 60	F 607: Develop/implement abuse/Neglect Policies – Ref #4 and 82) 1. Resident #4 was rea by the Director of November 7. DON or allegation with resid does not recall being handled roughly. The interviewed staff who attended to resident 8/23/21. Complaint or reported to the Resing Care Coordinator or The Resident Care Coordinator assesse #4 on 8/23/21 and documented findings resident's medical resident had no composite of pain or any bruising at the time of the coninvestigation. 2. All complaint allegate were reviewed and the were no other allegated identified that would the level of abuse or	assesse ursing of discusse ent who gent who on was dent a 8/23/2 ed Res on ecord. Ation, aplaints and notes there tions rise to	ad n ed 1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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STODDAR	RD BAPTIST NURSING H	OWE	WASHINGTON, DC 20010		VASHINGTON, DC 20010			
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1/10		,	,,,,,		DEFICIENCY)			
F 607	Continued From page	e 16	F6	807	E 007 E side abilit O sufficient			
	and Pain.				F 607 - Resident #4 Continued			
	Decision of a Facility D	Associated Association (EDI)						
	•	eported Incident (FRI),			3 The Administrator provide	d		
		ed by the State Agency on I, "Charge nurse was			the Social Services Staff,	_		
		nber that [Resident #4] said			DON, Nursing Supervisor	S,		
		ne care provided to her			and charge nurses an in-	•		
	she complained that h	•			service on the process for			
	handled roughly"				conducting an investigation			
	• •				of facility reported inciden	ts,		
	Review of Resident #4	4's medical record showed			including abuse and			
	the following:				elopement on 12/17/21.			
	An Admission Minimu	m Data Set (MDS) dated			4. Any resident complaint or			
		ity staff coded: severe			reported incidents of abus			
		rejection of care occurred			will be monitored to ensur	e a		
	- 1	ssistance with two persons			thorough investigation is			
	physical assist for bed	I mobility, transfers, toilet			conducted with written			
	use; extensive assista				statements from persons			
		sonal hygiene and dressing;			who may have knowledge			
		airment in range of motion			the event. Any finding from			
	for upper or lower extr	emities.			the audit conducted will be			
	00/22/24 04 42:25 084	[Nursing Note] "[Posident			discussed monthly at QAF meeting.	1		
		[Nursing Note] "[Resident nd verbally responsive with			meeting.			
		Per family member, she			5. Completion Date: January	9.		
		ned that her left side has			2023	-1		
I .	, ,	head to toe assessment						
	· ,	or any open injuries were			Director of Social Services	;		
		esident in her room with						
		arge nurses. She was lying						
		nished her breakfast. Writer						
,		e is doing. She said she is						
	-	d not make any further]	
	complaint"							
	Review of the facility's	investigation packet						
	revealed no document							
	statements from staff v	who might have knowledge						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	1G			С	
		095020	B. WING_				/09/2022	
NAME OF P	ROVIDER OR SUPPLIER		<u>' </u>	STREE	TADDRESS, CITY, STATE, ZIP CODE			
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OTOBBA	NO DAI TIOT HOROMOTI			WASH	INGTON, DC 20010			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	on the alleged abuse	were obtained as part of the	F6	07	Resident #82 The Incidents for Resident #8	2		
	investigation for Resident Interview for Mental St score of "08", indicatin cognition; needing limit person physical assist locomotion on the unit person physical assist locomotion on the unit person physical assist locomotion of a face to AM Nursing/DON) stated, allegations of abuse, see if the rest of it [inv downstairs." It should be noted that documents were proved by the exit date of the 2. Facility staff failed the evidenced by the failure Resident #82's unwith abuse, and elopement Resident #82 was admos/19/21 with multiple Dementia, Difficulty With Status, and Unspecified A review of Resident # revealed the following: Quarterly Minimum Date of 108", indicatin cognition; needing limit person physical assist locomotion on the unit person physical assist	interview conducted on , Employee #2 (Director of "The process is for any to investigate. I will look to restigation documents] is to no other investigation ided to the State Surveyor survey. In implement its policy re to thoroughly investigate essed fall, allegation of the state of the facility on diagnoses that included: ralking, Altered Mental ed Fall. In its Set (MDS) dated the state of the satus (BIMS) summary genoderately impaired the dassistance with one to walk in the room and supervision requiring one to walk in the corridor; no of exhibited; and no falls			was reported to the state age at the time of the incidents. The Director of Nursing visited Resident #82 on 11/7/22. Resident did not recollect the events presented on the reported incidents (unwitness fall, allegation of abuse, elopement). The DON conducted staff interviews. Of one staff member remains at facility as it pertains to the unwitnessed fall, and that individual does not recall the incident. As it pertains to the abuse and elopement the staff were interviewed. All complaint allegations were reviewed and have not identified any allegations that would rise level of abuse or neglect. All resident charts will be reviewed for unwitnessed falls and investigated thoroughly. Ther were no other incidents of elopement.	ed nly		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	(EACH DEFICIENC	HOME TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	1818 WAS	ET ADDRESS, CITY, STATE, ZIP CODE NEWTON ST. NW HINGTON, DC 20010 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
:	"Resident called the needed help to get us the room, she was on side on the floor beside on the floor beside on the floor beside on Pt's (patients) retudiagnosed of lumbar. On 09/30/21 at 10:17 documented, "Resist the floor and needed On arrival in the room on the floor beside her the floor and needed On arrival in the room on the floor beside her the floor and incident repwho indicated that [R "Staff hit her with tray around lunch time" In resident who diagnos anxiety disorder, Cog Vascular dementia we Altered mental status declined incident hap On 10/20/21 at 2:23 f submitted to the State "Allege incident repwho indicated that [R "Staff hit her with tray around lunch time" 12/17/21 at 4:26 PM "Family friends visit walked out, she walked Staff went to check or side was side walked staff went to check or side walked staff wal	[Nursing Progress note] at she was on the floor and p at 6:30 am. On arrival in bserved laying on her left de her bed" [Progress note] "Follow up urn from the Hospital: Pt was vertebra fracture" 7 PM, a FRI, DC00010305, dent called that she was on help to get up at 6:30 am. n, she was observed laying er bed" [Nursing Progress Note] forted by another resident esident #82] reported to him on her head yesterday treviews with involved these includes dementia, initive communication deficit, with behavioral disturbance, and hypertension. She pened" PM, a FRI, DC0001033, as Agency documented, orted by another resident esident #82] reported to him on her head yesterday [Nursing Progress note]	F6		All reported facility incidents including unwitnessed falls/injury, allegations of abuse, and elopement will be monitored to ensure a thorough investigation a documentation to prever recurrence. Any finding from the audit conducted will be discussed monthly at QAPI meeting. 5. Completion date: Jan 9, 2023 6. Director of Social Services	nd nt	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	095020	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COI	ne .	11/09/2022	
	RD BAPTIST NURSING H	OME		1818 NEWTON ST. NW WASHINGTON, DC 20010	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B	E COMPLETION	
SS=D	at 3:10 pm on Decement of the composition of the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no document further occurrence of the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no document further occurrence of the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no documenter further occurrence of the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no documented further occurrence for the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no documented for the facility for the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no documented for the facility for the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no documented for the facility for Resident #82's fall abuse on 10/19/21 and lacked documented expossible knowledge of interviewed or that state and there was no documented expossible knowledge of interviewed or that state and there was no documented expossible knowledge of interviewed or that state and there was no documented expossible knowledge of interviewed or that state and there was no documented expossible knowledge of interviewed or that state and there was no documented expossible knowledge of interviewed or that state and there was no documented expossible knowledge of interviewed or that state and there was no documented expossible knowledge of interviewed or that state and there was no documented expossible knowl	found and returned to facility aber 17th, 2021" PM, a FRI, DC00010470, ly friends visited and when he walked behind them to check on resident and fine (sp) either of them. mmediately" P's investigation documents on 09/29/21, allegation of ad elopement on 12/17/21 vidence that: everyone with f the incidents were attements were obtained; umented measures taken to ences. Interview conducted on Employee #2 (Director of "I don't have those records ints]." Orrect Alleged Violation (4) e to allegations of abuse, or mistreatment, the facility vidence that all alleged hely investigated. further potential abuse, or mistreatment while the press.	F 6				
	§483.12(c)(4) Report t	ne results of all					

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_			С
		095020	B. WING			11	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		18	STREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	designated represent accordance with State Survey Agency, within incident, and if the allea appropriate corrective This REQUIREMENT by: Based on record revitwo (2) of 41 sampled failed to conduct a thoresident's allegation of unwitnessed fall, allegelopement. Residents The findings included: Review of the policy erevised 09/20/21 documents abuse will be investigation give in which was a considered to the facility's Resident Abuse/Abuse revision date of 09/24/1"Abuse means willfur unreasonable confiner punishment with result mental anguishNeglegoods and services new harm, mental anguish, illnessInvestigate difficulting and Identify the staff minitial reporting of resure authoritiesHuman Recopy of the investigation.	administrator or his or her ative and to other officials in a law, including to the State in 5 working days of the eged violation is verified action must be taken. Is not met as evidenced ew and staff interview, for residents, facility staff prough investigation of one of abuse and one resident's pation of abuse, and "#82 and #4. Intitled, "Social Service wance and Complaints" immented, " All suspected ated, with a report of such riting to the Administrator" Is policy titled "Prohibition of the Prevention" with s 122, revealed the following, I infliction of injury, ment, intimidation, or the ting physical harm, pain or ext means failure to provide excessary to avoid physical or mental ferent types of incidents, member responsible for the lits to the proper esources will complete a	F	610	1. Resident #4 was reassessed by the Direct of Nursing (DON) on November 7. DON discussed allegation with resident who does not rec being handled roughly. T DON interviewed staff wh attended resident on 8/23/21. Complaint was reported to the Resident Care Coordinator (RCC) 8/23/21. The RCC assessed Resident #4 documentation, resident #4 documentation, resident in no complaints of pain or a bruising noted a the time the complaint investigation 2. All complaint allegations were reviewed and have i identified any allegations that would rise to level of abuse or neglect.	call the o on nad any of n	

AND DIAN OF CORRECTION IN IMPER			` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095020	B. WING			C 11/09/2022	
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	181 WA	REET ADDRESS, CITY, STATE, ZIP CODE 8 NEWTON ST. NW ASHINGTON, DC 20010 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	3E	(X5) COMPLETION DATE
	Resident #82's unwitr abuse and elopement Resident #82 was add 03/19/21 with multiple Dementia, Difficulty V Status, and Unspecific A review of Resident revealed the following Quarterly Minimum Do 07/21/21 showed facil Interview for Mental S score of "08", indicating cognition; needing limperson physical assist locomotion on the unit person physical assist wandering behavior makes admission/entry assessment. 09/29/21 at 9:08 AM [I"Resident called that needed help to get up the room, she was obside on the floor beside on the floor beside on 19/30/21 at 9:04 AM [I on Pt's (patients) return diagnosed of lumbar v On 09/30/21 at 10:17 idocumented, "Resident called the floor and needed help or and needed h	mitted to the facility on diagnoses that included: /alking, Altered Mental ed Fall. #82's medical record: ata Set (MDS) dated ity staff coded: Brief tatus (BIMS) summary ag moderately impaired ited assistance with one to walk in the room and supervision requiring one to walk in the corridor; no obtexhibited; and no falls or reentry or the prior Nursing Progress note] the was on the floor and at 6:30 am. On arrival in served laying on her left e her bed" Progress note] "Follow up in from the Hospital: Pt was ertebra fracture" PM, a FRI, DC00010305, ent called that she was on elp to get up at 6:30 am. she was observed laying	F	310	Resident #4 continued 3. The Administrator provided the Social Services staff, DON, nursing supervisors and charge nurses an in-service on t process for conducting a investigation of facility reported incidents, includabuse and elopement on 12/14/22. 4. Any resident complaint or reported incidents of abut will be monitored to ensure a thorough investigation is conducted with written statements from persons who may have knowledge of event. Any finding from the audit conducted will be discussed monthly at QA meeting. 5. Completion date: January 9, 2023 6. Director of Social Services	n ling r se re	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		095020	B. WING _			11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	OME			18 NEWTON ST. NW		
			WASHINGTON, DC 20010				
(X4) ID	1	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	_	(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	`	CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
					Resident #82		
F 610	Continued From page	22	F6	310			i
		Nursing Progress Note]			1. The Incidents for Resident #8	_	
		orted by another resident	!		was reported to the state ager		
		esident #82] reported to him			at the time of the incidents. T	ne	
	_	on her head yesterday			Director of Nursing visited		
	around lunch time" Int			ĺ	Resident #82 on 11/7/22. Resident did not recollect the		
	resident who diagnose				events presented on the		
		nitive communication deficit, th behavioral disturbance ,			reported incidents (unwitnesse	-d	
		and hypertension. She			fall, allegation of abuse,	,	
	declined incident happ			- 1	elopement). The DON		
					conducted staff interviews. Or	niy	
	On 10/20/21 at 2:23 P	M, a FRI, DC0001033,			one staff member remains at	,	
	submitted to the State				facility as it pertains to the		
	"Allege incident repo	orted by another resident			unwitnessed fall, and that		
		esident #82] reported to him			individual does not recall the		
		on her head yesterday			incident. As it pertains to the		
	around lunch time"				abuse and elopement the staff		
	12/17/21 at 4:26 DM [I	Nursing Progress note]			were interviewed.		
	"Family friends visite				2. All complaint allegations were		
		d behind them unnoticed.			reviewed and there were no oth	er	
		the resident and visitors			allegations identified that would		
		either of them. Code pink			rise to level of abuse or neglect.		
	activatedResident for	ound and returned tofacility			All residents' charts will be		
	at 3:10 pm on Decemb	per 17th, 2021"			reviewed for unwitnessed falls a	na	
					investigated thoroughly. There were no other incidents of		
		M, a FRI, DC00010470,			elopement.		
		y friends visited and when					
	the (sp) walked out, sh	ne walked behind them o check on resident and			3. The Administrator/designee		
		ine (sp) either of them.			provided the Social Services Sta	ıff,	İ
	Code pink activated im				DON, Nursing Supervisors, and	.	1
	Julia piini dollivatod III				charge nurses an in-service on t	he	
	A review of the facility's	s investigation documents			process for conducting an investigation of facility reported		
	-	on 09/29/21, allegation of			incidents, including abuse and		
		d elopement on 12/17/21			elopement on 12/14/22		
		idence that: everyone with					
	possible knowledge of					j	ĺ
	interviewed or that stat	ements were obtained;					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С	
		095020	B. WING		11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CTODDAG	D DADTICT MUDCING U	ORAE		1818 NEWTON ST. NW		
STOUDAR	RD BAPTIST NURSING H	OWE		WASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF CORRECTION	(X5)	
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F 610	Continued From page	23	F 610	Resident # 82 (Continued)		
	and there was no doc prevent further occurr	umented measures taken to ences.				
	11/07/22 at 1:15 PM,	interview conducted on Employee #2 (Director of "I don't have those records nts]."		4. All reported facility incidents including unwitnessed falls/injury, allegations of abuse, and elopement will be monitored to ensure a thorough investigation and documentation to prevent recurrence. Any finding from the audit conducted will be		
	2. Facility staff failed to conduct a thorough investigation of Resident #4's allegation of abuse (being handled roughly by staff).			discussed monthly at QAPI meeting. 5. Completion date: Jan 9, 202	3	
	Resident #4 was admi 07/08/21 with diagnos and Pain.	itted to the facility on es that included: Dementia		6. Nurse Educator		
	DC00010213, received 08/24/21 documented, notified by family mem	ber that [Resident #4] said e care provided to her				
- 1	Review of Resident #4 the following:	s's medical record showed				
	07/15/21 showed facili cognitive impairment; r 1-3 days; extensive as physical assist for bed use; extensive assistar physical assist for pers	rejection of care occurred sistance with two persons mobility, transfers, toilet noce with one person sonal hygiene and dressing; irment in range of motion				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		095020	B. WNG_			C	
NAME OF P	ROVIDER OR SUPPLIER	033020		STREET ADDRESS, CITY, STATE, ZIP C	CODE	11/09/2022	
STODDA	RD BAPTIST NURSING H	ОМЕ		1818 NEWTON ST. NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B HE APPROPRI	0.77	
F 610	Continued From page	÷ 24	F6	310			
	#4] is alert, oriented a intermittent confusion (Resident #4) compla been handled roughly was done. No bruises noted. Writer visited resocial Worker, and chin bed. She had just fi asked resident how st doing fine. Resident domplaint" Review of the facility's revealed no document statements from all staknowledge on the alle as part of the investigation. During a face-to-face in 1/07/22 at 11:25 AM, Nursing/DON) stated, allegations of abuse, to some plant of the investigations.	ted evidence that aff who might have ged abuse were obtained					The second secon
	It should be noted that documents were provi by the exit date of the	ded to the State Surveyor					
1	Cross reference DCMI Admission Physician C CFR(s): 483.20(a)	R 3232.2 Orders for Immediate Care	F 63	35			
	§483.20(a) Admission At the time each reside must have physician o	ent is admitted, the facility					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING				ĺ	C
NAME OF B	ROVIDER OR SUPPLIER		1			ODEOG OUD/ OTATE TIP OODE	17.	/09/2022
NAME OF P	ROVIDER OR SUPPLIER					DRESS, CITY, STATE, ZIP CODE		
STODDAR	RD BAPTIST NURSING H	OME			1818 NEWT			
				'	WASHING	TON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION	_	(X5)
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1710		,				DEFICIENCY)		
				•	EGSE	racident #200		
F 635	Continued From page	25	F	635		- resident #298		
	immediate care.					The Director of Nursing re-		
		is not met as evidenced			1.	The Director of Nursing re- assessed Resident #298 o		
	by:					11/8/22 and reviewed	13	
	•	ew and staff interview, for						
		residents, facility staff	•			documentation on 11/8/22.		
	failed to ensure that o	•				An order for an indwelling catheter was obtained for		
	physician's order for a	n indwelling catheter.				Resident #298 on 11/8/22.		
	Resident #298.	ŭ				There were no negative		
						outcomes as a result of this	,	
	The findings included:					deficient practice.	•	
	· ·				2.	•		
	During a facility tour co	onducted on 10/31/22 at			۷.	reviewed for admission		
	approximately 3:15 PM	/I, Resident #298 was				orders, specifically for foley		
	observed in her room	with her urine collection				catheter orders. There were		ĺ
	bag uncovered, visible	to visitors and other				no other residents affected		
	residents from hallway	' .	l.			by similar deficient practice	in	
						other 4/4 residents with Fol		
		mitted to the facility on				catheters.	,	
		diagnoses that included			3.	An in-service on Admission		
	Overactive Bladder an	d Change in Bowel Habit.			-	Orders was provided by the	1	
						Director of Nursing to the		
	A review of the medica	al record revealed the				Licensed Nurses on 11/8/22	2.	
	following:				4.	The Director of Nursing (or		
	40/00/00 104	N. C. III. P. D. C. C.				designee) will audit all new		
		gress Note] " [Resident				resident's physician		
1	#298]newly admitted					admission orders to ensure		
	Catheter was placed					residents receives necessa	ry	1
1		d void trial and catheter				care and services on		
		be on until next follow up				admission. Audit findings wi	11	1
	with urology"					be monitored and findings		
	10/20/22 [History and [Physical] " Patient has an				shared with QAPI monthly.		
		ed in the hospital due to			5.	Completion date: Jan. 9,		l
	urinary retention"	od in the hospital due to				2023		ļ
	annary retendon				6.	Director of Nursing		
	Care plan focus area "I	ndwelling catheter"						
		d the goal of, "Resident will						1
	have catheter care mar							
		iting signs of infection or						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	' '	E SURVEY PLETED
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		095020	B. WING			11	1/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		1818 1	ET ADDRESS, CITY, STATE, ZIP CODE NEWTON ST. NW HINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
SS=E	urethral trauma" From the date of adm (nine days later), there evidence of a physicia #298's indwelling urin During a face-to-face 11/08/22 at 3:35 PM, Nursing/DON) stated, catheter, she [Resider evening." Accuracy of Assessme CFR(s): 483.20(g) §483.20(g) Accuracy of The assessment must resident's status. This REQUIREMENT by: Based on record reviet three (3) of 41 sample failed to ensure that re (MDS) assessments w status at the time of the #348, #69, and #68. The findings included: 1. Facility staff failed to	ission, 10/31/22 to 11/08/22 e was no documented an's order for Resident ary catheter. interview conducted on Employee #2 (Director of "There is no order for the at #298] came in the ents of Assessments. accurately reflect the is not met as evidenced ew and staff interviews, for d residents, facility staff esidents Minimum Data Set vere coded to reflect of their e assessments. Residents'	Fe	635 R 1	es. #348 1. Resident #348 was reassess for pressure ulcer risk on 12/by MDS coordinator. No preulcer was noted during identitimeframe. MDS was modifier eflect assessment re: pressurulcer risk on 12/12/22. There were no negative outcome as result of this deficient practice. 2. All charts were reviewed to identify residents at risk for pressure ulcers. All residents risk for pressure ulcers. All residents risk for pressure ulcers based the Braden scale were asses for accuracy of MDS coding. correction to MDS will be upon No additional residents were found to be affected by is defining practice. 3. The Director of Nursing proving all MDS coordinators an in-secon accurate coding of pressurulcers/Section M on 12/8/22. The DON will review MDS of residents with pressure ulcer for accurate MDS coding qual	12/22 ssure fied d to tre a a a a ton sed Any ated cient ded rvice risks terly	
	Admission MDS. Resident #348 was ad 08/12/22 with diagnose	miplegia and Hemiparesis, /eakness, and Mixed			and findings reported to QAP Completion date: January 9, 2 Director of Nursing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
			D 147110				С
L		095020	B. WING			11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
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0.0227		· • · · · · · · · · · · · · · · · · · ·	1	WASHINGTO	N, DC 20010		
(X4) ID	1	ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	NEODEATORY OR	EGO IDENTIL TING IN OKWATION	IAG	CRO	DEFICIENCY)	"\	
F 641	Continued From page	e 27	F 64	Reside	ent #69		
					D - 11 - 1 #00		
	A review of Resident	#348's medical record		1.	Resident #69 was		
	revealed:				reassessed by the MDS		
					Coordinator and medical		
	Physician's orders:				record reviewed on		
	00/40/00 !! A	O T- O!			12/9/22. The MDS		
	08/12/22 "Apply Barri Buttocks and Peri-are				coordinator completed		
	bullocks and Pen-are	ea Every Stillt.			the modification as it		
	08/12/22 "Monitor for	Bruising/Bleeding every			pertains to falls. There		
	shift."	Didishig/Blocking every			was no negative		
					outcome as a result of		
	08/12/22 "Turn and R	epositioning Q (every) 2		_	this deficient practice.		
	hours."			2.	All residents who		
					experienced falls will be		
		Braden Scale for Prediction			reassessed for accurate		
		ː] "Calculate Points and			coding of falls/Section J		
		Interpretation of Score:			and will be modified as		
	15-18 -At Risk"				required.		
	Care plan initiated an	09/42/22 Cataman Strim		3.	The Director of Nursing		
		08/13/22 "Category Skin nt #348] has impaired skin			provided all MDS		
	• •	on mid-chest, abrasion to			coordinators an in-		
		pilateral lower extremity			service on accurate		
	edema"	sharer ar review extremity			coding of falls on		
					12/8/22.		
	The Admission MDS	dated 08/17/22 showed		4.	The DON will review the		
	facility staff coded: se-	vere cognitive impairment;			MDS of all residents with		
	always incontinent for	bowel and bladder; had no			falls for accurate MDS		
	•	ot at risk for developing			coding quarterly and		
	pressure ulcers/injurie	s.			findings reported to		
	During to 1 f	44/00/00			QAPI.		
	•	Interview on 11/08/22 at			Completion date: 1/9/23		
	1:15 PM, Employee #9 acknowledged that fac			6.	Director of Nursing		1
	coded the Resident as	•					
1	pressure ulcers.	at hak for developing					1
	prossure uleers.						İ
							1
			1	1			- 1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		095020	B. WING _			1.	1/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		18	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	2. Facility staff failed in number of falls that R facility on the Quarter Resident #69 was add 06/14/22 with diagnos Falls, Parkinson's Dis Idiopathic Neuropathy A review of Resident revealed: 07/27/22 at 9:13 PM ["During med pass in the writer found Resident floor in her room, write happened, and she safrom her bed. she den floor" 07/28/22 [Care Plan]: #69] had a fall on 7/27 mobility/disease proces A Quarterly MDS date staff coded: moderate had 2 (two) falls since assessment. It should be noted that Resident #69 had no compared that the coded Resident #69 as for the Quarterly MDS afor the Quarterly MDS afor the Quarterly MDS afor the Quarterly MDS afor the Quarterly MDS	to accurately record the esident #69 had in the ly MDS dated09/15/22. mitted to the facility on ses including Repeated ease and Hereditary and formula in the evening around 5:45 PM, laying on her side, on the er asked her what hid she [slid] to the floor side hitting her head on the evening around 5:45 PM, laying on her side, on the er asked her what hid she [slid] to the floor side hitting her head on the evening around 5:45 PM, laying on her side, on the er asked her what hid she [slid] to the floor side hitting her head on the evening around 5:45 PM, laying on her side, on the evening around 5:45 PM, laying on her side, on the evening around 5:45 PM, laying around floor side hitting her head on the evening around floor side of 0. "Category: Falls[Resident 1/22 due to impaired ess" d 09/15/22 showed facility ly impaired cognition; and admission or prior to other than on 07/27/22, other documented falls. Interview on 11/08/22 at 80 (MDS Coordinator) sility staff inaccurately shaving 2 falls instead of 1	F	541	Resident #68 1. Resident #68 was reassessed by the MDS Coordinator and medical record reviewed on 11/7/22. The MDS Coordinator completed the modification as it pertains to falls. There was no negative outcome as a result of this deficient practice. 2. All residents who experienced falls will be reassessed for accurate coding of falls/Section J and will be modified as required. 3. The Director of Nursing provided all MDS coordinators an inservice on accurate coding of falls on 12/8/22. 4. The DON will review MDS of all residents with falls for accurate MDS coding quarterly and findings reported to QAPI. 5. Completion Date: 1/9/23 6. Director of Nursing		
	#69] had a fall on 7/27 mobility/disease proces A Quarterly MDS date staff coded: moderate had 2 (two) falls since assessment. It should be noted that Resident #69 had no compared to the coded Resident #69 as for the Quarterly MDS	d 09/15/22 showed facility ly impaired cognition; and admission or prior other than on 07/27/22, other documented falls. Interview on 11/08/22 at 0 (MDS Coordinator) ility staff inaccurately shaving 2 falls instead of 1 dated 09/15/22.			coordinators an inservice on accurate coding of falls on 12/8/22. 4. The DON will review MDS of all residents with falls for accurate MDS coding quarterly and findings reported to QAPI. 5. Completion Date: 1/9/23		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		095020	B. WING _		<u>.</u>	C 11/09/2022
	PROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STA 1818 NEWTON ST. NW WASHINGTON, DC 20010	,	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTION CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	5.77
F 656 SS=F	#68's Minimum Data he had a fall. Resident #68 was ac 06/17/22 with multipl Difficulty in Walking, Other Abnormalities Review of Resident a revealed the followin 07/28/22 at 11:15 PM pm, attention drawn [Resident #68] who wroommate. When asl resident could not ex was walking round the Care plan focus area 7/28/22 due to poor j initiated on 07/28/22. A MDS dated 09/01/2 coded, "no falls since assessment". During a face-to-face 11/07/22 at 1:31 PM, Coordinator) reviewe fall is supposed to be correction now." Develop/Implement CCFR(s): 483.21(b)(1) The faci implement a compreh	Imitted to the facility on e diagnoses that included: Muscle Weakness and of Gait and Mobility. If [Nursing Note] " At 10:37 by the charge nurse to was said to have fallen by the sed how it happened, plain but roommate said he e room and tripped." If [Resident #68] had a fall on udgment/disease process" If [Sesident #68] had a fall on udgment/disease process in the fact of the MDS and stated, "The coded. I'll make the comprehensive Care Plan (3)	F 65			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING					COMPLETED	
		095020	B. WING			C 11/09/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT 1818 NEWTON ST. NW WASHINGTON, DC 2	ı .	1 1/05/2022
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENCY REGULATORY OR Continued From page resident rights set for §483.10(c)(3), that inc objectives and timefra medical, nursing, and needs that are identifi assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re under §483.10, includ treatment under §483 (iii) Any specialized se	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 30 th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ided in the comprehensive aprehensive care plan must prehensive care plan must plan must plan must plan must plan must plan must plan must plan must p	ID PREFIX TAG	F 656 – Res 1. Resi facili corre mad 2. All o care asse for ir inter asse were need 3. The provi in-se plani	er's PLAN OF CORRECTION RRECTIVE ACTION SHOULD BERENCED TO THE APPROPRIDE TO THE APPROPRIDE TO THE APPROPRIMENT OF THE APPROPR	the completion date
	provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv) In consultation with resident's representat (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Faci whether the resident's community was assess local contact agencies entities, for this purpos (C) Discharge plans in plan, as appropriate, in requirements set forth section. §483.21(b)(3) The service in the recommendation of the service of the passes of the plans in plan, as appropriate, in requirements set forth section.	a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the five(s)-fills for admission and ference and potential for lities must document desire to return to the sed and any referrals to and/or other appropriate se.		imple intervand of interval in	ementation of vention as directed, documentation of ventions performed. ervice is on-going, ed 11/14/22. DON or designee will ew residents care plankin care for resident ered and orehensive care planthly. Findings will be red to QAPI monthly pletion date: Jan. 9,	n

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING					1PLETED	
		095020	B. WING				C
	ROVIDER OR SUPPLIER		313	S1 18	TREET ADDRESS, CITY, STATE, ZIP CODE 318 NEWTON ST. NW VASHINGTON, DC 20010	1	1/09/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	care plan, must- (iii) Be culturally-com. This REQUIREMENT by: Based on record revifour (4) of 41 sampled failed to develop and patient-centered care and approaches to m physical, mental and Residents' #350, #32. The findings included 1. Facility staff failed to assessments per Resident #350 was admitted 10/23/19 with Cerebral Vascular Accidents and Complaint, DC00010 Agency on 12/30/21 described for the pressure wounds in the pressure wounds in the condition of and care to receiving, our office is	petent and trauma-informed. This not met as evidenced are and staff interviews for different comprehensive plans that included goals eet resident's medical, psychosocial needs. #299, and #26. To implement daily skin ident #350's care plan. Idmitted to the facility in diagnoses including cident, Peripheral Vascular Gastrostomy Status, Lower, and Generalized Muscle 10482, received by the State ocumented, "[Hospital ned that the physician ort due to the condition of a call was placed to the different to the complaint about the complaint about the hat the member was submitting the complaints for review and investigation	F	656			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
				-			С
		095020	B. WING			11	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 32	F	356			
	barrier cream to sacru	[physician's order]: "Apply um, buttocks, and peri-area care for skinprotection."					
	10/24/19 at 12:16 PM for Bruising/Bleeding	[physician's order]: "Monitor every shift."					
	10/24/19 at 12:16 PM and Repositioning Q ([physician's order]: "Turn (every) 2 hours."					
	[Resident #350] has p skin integrity, r/t (relate	"Category: Skin Integrity octential for impairment of ed to) peripheral vascular Assess skin condition daily s"					
	showed facility staff or for bed mobility and ed dependent" for transfed dressing, bathing, and addition, facility staff of having no pressure uld	ers, locomotion, toileting, I personal hygiene. In coded the Resident as cers, having two venous d at risk for developing					
	observed with [an] into measuring 3 cm (centi shift. PMD (Primary Mand) ordered to cleans	Nursing Progress Note]: " act blister in the sacrum meter) x 3.5 cm x 0 cm this edical Doctor) made aware se the area with normal n ointment and leave open d doctor"					
	initial skin sheet: intact Assessment: Weekly S	Skin Sheet]: "Description t sacral blister, Type of Skin SkinLocation: Sacrum, Stage 2, Type of Wound:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		005000	B. WING				С
NAME OF D	DOVIDED OD SLIDDI IED	095020	b. Wild		STREET ADDRESS, CITY, STATE, ZIP CODE	11	/09/2022
	ROVIDER OR SUPPLIER	A			1818 NEWTON ST. NW		
STODDA	RD BAPTIST NURSING H	OME		١	WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Blister, Appearance: 6Length: 3.0 cm, Wid Care plan initiated on Ulcer/Wound (skin)/ and note any changes From 12/07/21 to 12/0 was no documented of assessed Resident #3 condition. December 2021 Treat (TAR) showed that fro facility staff initialed to applying barrier crean buttocks, and peri-are care for skin protectio skin for bruising and be were turning and report two hours. 12/10/21 at 10: 56 AM "Resident seen today Physician]/wound tear assessment and evaluation.	Clean, Drainage: None of th: 3.5 cm, Depth: 0 cm." 12/06/21: "Category Assess skin condition daily so, treatment as indicated" 29/21 (three days), there evidence that facility staff as50's sacral area or skin temperature and the sacration of the resident's sacram, a after each incontinent or, monitoring the resident's seleeding every shift and astitioning the resident every to the sacram of the resident every the sacram of the resident every the sacram of the resident every the sacram of the resident every the sacram of the resident every the sacram of the resident every the sacram of the resident every the sacram of the resident every the sacram of the sacram	F	656			
		o documented evidence sed Resident #350's sacral					
	showed facility staff in were: applying barrier sacrum, buttocks, and incontinent care for sk	dministrated Record (TAR) itialed to attest that they cream to the resident's peri-area after each in protection; monitoring oruising and bleeding every					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING			1 11	C 1/09/2022
	ROVIDER OR SUPPLIER			18	TREET ADDRESS, CITY, STATE, ZIP CODE 318 NEWTON ST. NW VASHINGTON, DC 20010		10312022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	shift and were turning resident every two ho December 2021 Medi Record (MAR) showe 12/11/21, facility staff were cleansing Resid normal saline, applyin leaving it open to air. 12/12/21 at 2:36 PM [initial skin sheet: intac Assessment: New WobuttocksLength: 5.5 0 cm." 12/12/21 at 3:19 PM [i"Resident was noted with the same to assess R (Nurse Practitioner) blister. New order to caline, apply bacitracin until seen by [Wound of the same to a same to a saline, apply bacitracin until seen by [Wound of the same to a same to a saline, apply bacitracin until seen by [Wound of the same to a same to a saline, apply bacitracin until seen by [Wound of the same to a same	and repositioning the urs. cation Administration d that from 12/06/21 to initialed to attest that they ent #350's sacral blister with g Bacitracin ointment, and Skin Sheet]: "Description to sacral blister, Type of Skin bundLocation: Left cm, Width: 5.5 cm, Depth: Nursing Progress Note]: with intact blister measuring upervisor made aware, and esident. Call placed to NP and he was made aware of lean area with normal in daily and leave open to air Care Physician]"	F	356			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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		095020	B. WNG		11/09/2022	
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			
	During an observation at 3:41 PM, Resident had started to swell at She said she had contime but believed they laundry to be cleaned surveyor noted that the edematous from the k on the resident's leg a areas at the outer knethat no facility staff had she did not mention have he will be she did not mention have leg below the Knee. Resident #32 was admo6/17/21 with diagnos Vascular Disease, Cellimb, Diabetes Mellitu Leg below the Knee. Review of Resident #3 revealed: 06/17/21 at 5:42 PM [remollient topical lotion for dry skin." Care plan initiated on the integrity [Resident #3 breakdown r/t (related cellulitis Approach: A presence of risk factors possible Report any (sore, tender, red or breshift"	and interview on 11/01/22 #32 stated that her left leg and would sometimes leak. Appression stockings at one awere taken with her and never replaced. The e resident's left leg was nee to the ankle. The skin ppeared dark with light pink e. The resident also stated dolooked at her leg because er concern to them. Initted to the facility on es including Peripheral Illulitis of the Left Lower as, and Absence of Right B2's medical record Chysician's order]: "Monitor every shift." physician's order]: n, apply 2x/day as needed D1/10/22: "Category: Skin B32 is at risk for skin to) lower extremity	F	1. Resident #32 was re-assess the Director of Nursing on 11 Resident was observed to hat cellulitis on left leg. MD notification new treatment order received plan revised Resident's evenskin assessment was review revised on 11/4/22. 2. All charts were reviewed to its residents with breakdown. A residents with skin breakdown assessed and all necessary plans were revised to reflect skin checks. 3. The DON re-educated the clistaff an in-service on the importance of developing carplans and implementing interventions as directed in the plan on 11/4/22 (on-going). 4. Care plans developed for reswith skin abrasion will be revifor appropriate interventions monthly and reported to QAF monthly. 5. Completion date: January 9, 6. Director of Nursing	/4/22. ave ed and d. Care y shift ed and dentify III rn were care weekly nical re ne care idents iewed	

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		IPLETED
		095020	B. WING				C 1/09/2022
	ROVIDER OR SUPPLIER			STF 181	REET ADDRESS, CITY, STATE, ZIP CODE 8 NEWTON ST. NW ASHINGTON, DC 20010	1	1709/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
	venous insufficiency. A Quarterly MDS data facility staff coded: a Status Summary Scocognition; required embility, transfers, lod dressing, toilet use, purctional impairment extremity; and was a ulcers. 09/19/22 at 1:45 PM "Complaint of drynelegordered Furoser Spironolactone 25 medema caused by fluadvised to continue to topical lotion) for drynelegApproach: Assertion Approach: Assertion 1/2 Treatment Administration facility staff initial "Monitor[ed] for bruisi applied "leg wrap with to left leg for venous in the facility staff initial "From 09/20/22 to 11/4 Medication Administration facility staff initial "emollient topical lotion" in the facility staff init	n leg wrap daily to left leg for " " " " " " " " " " " " "	F	656			

PRINTED: 12/30/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IG		COMPLETED	
		095020	B. WING _			C 11/09/2022
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	no evidence that faci assessment and the left lower extremity to pain and swelling in changes and deterior. During a face-to-face 11/07/22 at 1:10 PM, Nursing/DON) acknownade no further com During a face-to-face 3:30 PM, Employee 4 reviewed the findings #32 and stated that withe skin assessments any new skin areas a existing areas. When the ulcers are part of	lity staff implemented a daily condition of Resident #32's include color, temperature, order to identify and report ration. interview conducted on Employee #2 (Director of wledged the finding and	F 6	56		
	non-compliance/refus interventions. Resident #299 was at 12/06/18 with multiple Heart Failure, Unilate Pressure Ulcer of Sac On 10/06/22 at 10:21 (DC00011017) was st that revealed the follo	antation of Resident #299's seal of care plan different to the facility on ediagnoses that included: ral Inguinal Hernia, and cral Region. AM, a Complaint submitted to the State Agency wing: " [Resident #299]'s apidly in the past month.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILD			SURVEY PLETED	
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		095020	B. WING			11	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		1:	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	ambulatory with an as one month ago. He had unable to walk, unable bed, often in a fetal prepared scrotum that that she feels no one. A review of the medical following: 07/05/22 [Quarterly Mark Facility staff coded: the Interview for Mental Siscore of 11, indicating cognition and that rejectly to (6) days but not 08/08/22 at 5:03 PM [IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	ssistive device until about as lost weight, is weak, at to feed himself, and lies in osition. He has had an a continues to grow in size has addressed" all record revealed the inimum Data Set (MDS)]: e resident as having a Brief tatus (BIMS) summary a moderately impaired action of care occurred four daily. Physician Progress Note] allow me to see his scrotum Nursing Progress Note] refusing all AM Nursing Progress Note] staff members refused eanalso refused ressure)/meds Nursing Progress Note] verbally responsive and ved this shift lying on his nens full of urine. Shower stated "I do not need offered, refused brief. Also (blood pressure) meds	F	959	 Resident # 299 was discha 10/5/22. No corrective actibe done during this timefra All other residents records reviewed and residents ide with refusal to care were a and care plan updated to a advantages of treatment a consequences of refusal. The interdisciplinary care pwas provided an in-service education on addressing renoncompliance by the Nur Educator on 12/14/22. Medical records of residen refusal to care/noncompliat therapeutic interventions were viewed monthly for docurefusal and care plan addressed for noncompliance and consection of noncompliance. Completion date: Jan. 9, 2 MDS Coordinator 	on could me. were ntified ssessed ddress and lan team esident se with nce with ill be mented essing quences	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		COMPLETED
		095020	B. WNG_			C 11/09/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 1818 NEWTON ST. NW WASHINGTON, DC 20010	,	1110312022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)	
F 656	09/25/22 at 11:39 PM "Resident was very evening care. He refu (Certified Nurse Aide) to him. He lay in his u him comply was met v Resident" A review of a care pla 09/27/22, documented -Compliance [Resident with plan of care; refu Non-compliance with refused covid -19 vacc the purpose and adva resident. Explain the consequences of refus refusal to physician. R refuse treatment (s). In	[Nursing Progress Note] uncooperative during sed the assigned CNA to provide incontinent care rine and all attempt to make with staff opposition from n with a revision date of d, "Problem: Non th #299] is non-compliance sed annual flu vaccine, assessment and treatment, cineApproach Reiterate intages of treatment for the disease process and sal of therapy. Report despect resident's rights to involve family as needed"	F 6	556		
	"Refused medicationRefused incontinent reposition (sp)" The medical record lact that facility staff impler reiterating the purpose treatment, explaining tonsequences of refus physician and involving non-compliance/refusation.	care, refused to be cked documented evidence mented the approaches of e and advantages of the disease process and eal, reporting refusal to the g family for Resident #299's				

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME CALL DEPCIENCY MUST BE PRECEDED BY FULL TAGE F. 656 COntinued From page 40 Practical Nurse) stated "Resident would refuse care initially he could do most of the things for himself." Employee #15 acknowledged the findings. During a face-to-face interview conducted on 11/07/22 at 10:53 AM, Employee #2 (Director of Nursing) acknowledged the findings and made no further comment. Cross reference DCMR 3210.4 4. Facility staff failed to develop a care plan to address the care of Resident #26's ischemic right foot and cellulitis. Resident #26 was admitted to the facility on 05/10/19 with diagnoses that included: Idiopathic Peripheral Autonomic Neuropathy. Type 2 Diabetes Mellitus and Muscle Weakness. Review of Resident #26s medical record revealed the following: Care plan focus area, "[Resident #26] is at risk for skin impairment r/t (related to) decreased mobility, incontinence, underweight" initiated on 09/10/19 had the following approaches, "Report any signs of skin breakdown (sore, tender, red, or broken areas). Provide diet and supplement as ordered. Dictary consult PRN (as needed)Keep clean and dry as possible. Minimize skin		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1	(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME CA4-)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL TAG) PREFIX (EACH DEPICIENCY MIST BE PRECEDED BY FULL TAG) PROVIDER'S PLAN OF CORRECTION (EACH OBTRICHY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICE ON THE APPROPRIATE DEPACE ON THE APPROPRIATE DEPICE ON THE APPROPRIATE DEPACE ON THE AP			005020	B MNG				
STODDARD BAPTIST NURSING HOME 1818 NEWTON ST. NW MASHINGTON, D.C. 200101 CALL D. SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D. PROVIDERS PLAN OF CORRECTION (EACH OPERICIENCY AUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D. PRECEDENCY	NAME OF D	BOVIDED OF STIPPLIED	095020	B. WiNG _		2005	11/09/2022	
CALID SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DPEREIX TAG PROVIDERS PLAN OF CORRECTION (REACH OPERICIPACY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (REACH OPERICIPACY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (REACH OPERICATE DETITION (REACH OPERICATE))	NAME OF P	ROVIDER OR SUPPLIER			• • • •	JODE		
F 656 Continued From page 40 Practical Nurse) stated "Resident would refuse care initially he could do most of the things for himself." Employee #15 acknowledged the findings. During a face-to-face interview conducted on 11/07/22 at 10:53 AM, Employee #2 (Director of Nursing) acknowledged the findings and made no further comment. Cross reference DCMR 3210.4 4. Facility staff failed to develop a care plan to address the care of Resident #26's ischemic right foot and cellulitis. Resident #26 was admitted to the facility on 05/10/19 with diagnoses that included: Idiopathic Peripheral Autonomic Neuropathy, Type 2 Diabetes Mellitus and Muscle Weakness. Review of Resident #26's medical record revealed the following: Care plan focus area, "[Resident #26] is at risk for skin impairment r/t (related to) decreased mobility, incontinence, underweight" initiated on 09/10/19 had the following approaches, "Report any signs of skin breakdown (sore, tender, red, or broken areas). Provide diet and supplement as ordered. Dietary consult PRN (as needed) Keep	STODDAF	RD BAPTIST NURSING H	OME					
Practical Nurse) stated "Resident would refuse care initially he could do most of the things for himself." Employee #15 acknowledged the findings. During a face-to-face interview conducted on 11/07/22 at 10:53 AM, Employee #2 (Director of Nursing) acknowledged the findings and made no further comment. Cross reference DCMR 3210.4 4. Facility staff failed to develop a care plan to address the care of Resident #26's ischemic right foot and cellulitis. Resident #26 was admitted to the facility on 05/10/19 with diagnoses that included: Idiopathic Peripheral Autonomic Neuropathy, Type 2 Diabetes Mellitus and Muscle Weakness. Review of Resident #26s medical record revealed the following: Care plan focus area, "[Resident #26] is at risk for skin impairment /t/ (related to) decreased mobility, incontinence, underweight" initiated on 09/10/19 had the following approaches, "Report any signs of skin breakdown (sore, tender, red, or broken areas). Provide diet and supplement as ordered. Dietary consult PRN (as needed)Keep	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TON SHOULD BE THE APPROPRIAT	COMPLETION	
exposure to moisture." 07/14/22 at 11:48 AM [Physician's Assistant Note] "Pt's (patient's) nurse reported that pt complained of big toe pain and redness [right toe]Pt admits to doing well and admits to pain to the footPlan:Order Colchicine (decreases		Practical Nurse) state care initially he could himself." Employee #findings. During a face-to-face 11/07/22 at 10:53 AM Nursing) acknowledge further comment. Cross reference DCM 4. Facility staff failed t address the care of Refoot and cellulitis. Resident #26 was adm 05/10/19 with diagnos Peripheral Autonomic Diabetes Mellitus and Review of Resident #2 the following: Care plan focus area, skin impairment r/t (rel mobility, incontinence, 09/10/19 had the followany signs of skin break broken areas). Provide ordered. Dietary consucted and dry as possi exposure to moisture." 07/14/22 at 11:48 AM "Pt's (patient's) nurse complained of big toe ptoe]Pt admits to doin	d "Resident would refuse do most of the things for 15 acknowledged the interview conducted on Employee #2 (Director of ed the findings and made no ed the findings and made no esident #26's ischemic right esident #26's ischemic right esident #26's ischemic right entitled to the facility on es that included: Idiopathic Neuropathy, Type 2 Muscle Weakness. 26s medical record revealed enderweight" initiated on wing approaches, "Report adown (sore, tender, red, or ed diet and supplement as all PRN (as needed)Keep ble. Minimize skin [Physician's Assistant Note] e reported that pt oain and redness [right g well and admits to pain to	F 6	 Resident #26 was care plan re: skin reviewed and upd current assessme for right foot on 11 All residents with conditions were an necessary care plans and several se	impairment ated to addint and treating int and treating int and treating interest and the assess and treating am were resent centered into a will review lents with for resident prehensive be reported Jan 9, 2023	was ress ment id all ment, nt. d care g) by the ot t care	

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F 656	swelling) 0.6mg (millig 1, then 1 tablet 1 hou exacerbation." 07/23/22 at 8:58 PM [seen at the request of [necrotic] foot and toe cellulitisDark big toe Keflex (antibiotic)" A Quarterly MDS date staff coded: required two persons physical required extensive as physical assist for perpressure ulcers; and represent. Review of Resident #2 plan showed that from was no evidence that patient-centered care approaches to addres right foot. During a face-to-face 12:21 PM, Employee 12:21 PM, Employee 13 Nurse) reviewed the compresent finding and made no finding	grams) tablet, give 2 tablet x r later for Gouty [Physician's Note] "Patient for ursing for ischemic with surrounding edry and cellulitisBegin [Physician's Note] "Patient for ursing for ischemic ewith surrounding edry and cellulitisBegin [Physician's Note] "Patient for ischemic ewith surrounding edry and cellulitisBegin [Physician's Note] "Patient for ischemic expense edro of the surrounding edry and cellulitisBegin [Physician's Note] "Patient for ischemic expense edro of plantitis. [Physician's Note] "Patient for ischemic expense expense edro of the plantitisBegin [Physician's Note] "Patient for ischemic expense edro of plantitisBegin [Physician's Note] "Patient for ischemic expense edro of the plantitisBegin [Physician's Note] "Patient for ischemic edro expense edro of the plantitisBegin [Physician's Note] "Patient for ischemic edro edro edro edro edro edro edro edro	F6				

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F 657	includes but is not lin (A) The attending phy (B) Aregistered nurse resident. (C) Anurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and the resident report practicable for the and their resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determinated or as requested by the (iii)Reviewed and revoteam after each assessments. This REQUIREMENT by: Based on record revisive (5) of 41 sampled failed to revise the composition of the co	responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined dedevelopment of the staff or professionals in ned by the resident's needs resident. Is ed by the interdisciplinary resment, including both the uarterly review is not met as evidenced rew and staff interview, for residents, facility staff mprehensive care plans reproaches for: one resident of infection (UTI); two red falls; one resident's right rene; and one resident's rite. Residents' #25, #80, orevise Resident #25's sis of Urinary Tract	F	F 657 – and 79 : 1. 1. 2. 4. 7 f v a r 5. (2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2	Resident # 25, 80, 26, 68 Resident #25 was assess by the DON on 11/7/22. Care plan for UTI was reviewed and revised to address goals and approaches for UTI. The care plan was subsequent resolved on 11/8/22. There was no negative outcome All residents with diagnost of UTI were assessed and all necessary care plans were revised to reflect goal that address UTIs. The Nurse Educator provided all RNs an inservice on comprehensive care plans with emphasistimely assessment and interventions to prevent and early for UTI, and goals are approaches updated on 11/4/22 (on-going). The DON (or designee) were view all care plans writted on the pool of the DON (or designee) were view all care plans writted on the pool of the DON (or designee) were view all care plans writted and reported to QAPI monthly. Completion date: Jan. 9, 2023 Director of Nursing	sed The attly re sis d als e on and and fill en	

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	Resident #25 was ac 10/25/18 with the foll Kidney Disease, Nor Ventricular Tachycar Generalized Muscle Review of Resident # the following: Care plan focus area "[Resident #25] has I pattern related to disease Dx (diagnosis) UTI 90 days. Approach Pfluids, record incontine wear incontinence paupdated 08/08/22 Uri (culture and sensitivity up by lab technician a "08/05/22 [physician's rule out UTI. Urine Condered Specimen for Cordered Specimen in up by the lab" "08/11/22 at 9:34 PM "Call placed to MD (murinalysis, culture and bacteria few and on Escherichia Coli orde 500 mg (milligram) 1 daily x7 days for UTI	dmitted to the facility on owing diagnoses: Chronic and Jagnoses:	F	657			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT			E SURVEY IPLETED			
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				18	818 NEWTON	ST. NW		
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F 657	oommada i iom paga		F 6	557				
		t #25's care plan with new			1	Resident #80 was		
		fter it was confirmed that he			1.	assessed by the DON on		
	had a UTI on 08/11/2	2.				12/27/22. Care plan		
	5					was reviewed and care		
	11/8/22 at 2:30 PM, E	interview conducted on				plan updated/revised with		
	•	dings and made no further				new goals to		
	comments.	ungs and made no futfile				prevent/minimize any		
	comments.					future falls on 12/27/22.		
					2.	All charts were reviewed		
	2. Facility staff failed t	o revise Resident #80's				to identify residents with		
	-	als and approaches after he				prior falls. All other		
	sustained multiple falls	s.				residents with prior falls		
						were reviewed for care		
	Resident #80 was adr					plan goal that addresses		
	-	diagnoses that included:		ĺ		minimizing or preventing falls on 12/27/22.		
		dent, Diabetes Mellitus,				Additional interventions		
	Hypertension, and Re	spiratory Distress.				were provided in the care		
	Review of Resident #8	20's modical record				plan as needed.		
	revealed the following				3.	The Nurse Educator		
	revealed the following	•				provided all licensed		
	Care plan focus area i	nitiated on 04/22/22				nurses an in-service on		
		sident #80] has likelihood				comprehensive care		
	for falls"	•				plans and to revise care]
						plan with new goals and		
		Nursing Progress Note]				approaches to falls		
		drawn by the charge nurse				prevention on 11/14/22		
		aid I have had a fall in her			4	(on-going).		
1		nt, resident was found lying			4.	The Falls Committee will review all new falls		
I	beside her bed with he	. •				weekly, update care plan		
- 1	oriented x2 MD noting	closely and to report to him				for fall if needed, and		
	if there is any changes					reported to QAPI		
		continue plan of care"				monthly.		
	r. 53. 223 (a. o.i.)g 44ii				5.	Completion date: Jan. 9,		
	There was no docume	nted evidence that facility			• •	2023		
1		#80's falls care plan with			6.	Director of Rehab		
	any new goals and app							

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	sustained a fall on 05 During a face-to-face 11/08/22 at 2:30 PM, Nursing/DON) acknown of further comments. 3. Facility staff failed to comprehensive care pactions, treatments are care of the resident's Resident #26 was adr 05/10/19 with diagnos Peripheral Autonomic Diabetes Mellitus and Review of Resident #2 the following: Care plan focus area, skin impairment r/t (remobility" initiated on approaches, "Report a (sore, tender, red, or band supplement as or (as needed)Keep cle Minimize skin exposur 07/14/22 at 11:48 AM "Pt's (patient's) nurse complained of big toe toe]Pt admits to doin the footPlan:Ordes welling) 0.6mg (millig 1, then 1 tablet 1 hour exacerbation."	interview conducted on Employee #2 (Director of wledged findings and made to revise Resident #26's plan with new approaches, and procedures to address right foot. mitted to the facility on the set that included: Idiopathic Neuropathy, Type 2 Muscle Weakness. 26s medical record revealed "[Resident #26] is at risk for lated to) decreased 09/10/19 had the following any signs of skin breakdown proken areas). Provide diet dered. Dietary consult PRN the an and dry as possible. The to moisture." [Physician's Assistant Note] the reported that pt pain and redness [right to great well and admits to pain to the colchicine (decreases rams) tablet, give 2 tablet x	F	657	2. 3.	Resident #26 was assessed by the DON on 11/4/22. Care plan to address current right foot treatment was revised on 11/4. All charts were reviewed to identify residents with skin breakdown. All other residents with potential for skin break down were assessed and care plan revised to reflect weekly skin assessment on 12/23/22. The Nurse Educator provided all interdisciplinary care plan team members an inservice on facility's comprehensive care plan policy on 11/14/22 (ongoing). The Nursing Supervisor will review care plans developed for residents with skin condition monthly and report to QAPI monthly. Completion date: January 9, 2023 Director of nursing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED	
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	Keflex (antibiotic)" A Quarterly MDS date staff coded: required of two persons physical required extensive as physical assist for per pressure ulcers; and a present. Care plan focus area, skin impairment r/t (re mobility" showed it we However, there was not facility staff first noted to the resident's right and approaches that a streatments, procedure of Resident #26's right. The evidence showed revise Resident #26's with new actions, treat address care of the result of the resident staff failed to the finding and made of the finding and made of the facility staff failed to the fac	f nursing for ischemic with surrounding and cellulitisBegin and c	F6	557		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING					COMPLETED	
		095020	B. WING _			C 11/09/2022
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F 657	Resident #68 was ac 06/17/22 with multiple Difficulty in Walking, Other Abnormalities are Review of Resident # revealed the following 07/28/22 at 11:15 PM At 10:37 pm, attention to [Resident #68] when the roommate. When resident could not exwas walking round the Care plan focus area 7/28/22 due to poor juinitiated on 07/28/22 (physical therapy)/OT consult PRN (as need ask for assistance and A Quarterly Minimum 09/15/22 showed faci adequate, no correcti impaired cognition; no extensive assistance assist for bed mobility moving from seated to only able to stabilize with functional impairment side for lower extremi wheelchair for mobility admission/reentry or preceived restorative in walking.	Imitted to the facility on e diagnoses that included: Muscle Weakness and of Gait and Mobility. 168's medical record g: 1 [Nursing Progress Note] " on drawn by the charge nurse of was said to have fallen by asked how it happened, plain but roommate said here e room and tripped." 1 [Resident #68] had a fall on addgment/disease process" and the approaches of, " PT of (occupational therapy) and the approaches of the call light within reach." 1 Data Set (MDS) dated lity staff documented: vision we lenses; moderately obehavior issues; required with one person physical of the transfers; balance during to standing was not steady, with staff assistance; in range of motion on one ties; used a walker and y; no falls since or or or sesessment; and	F	was reviewed additional appropresention/mir future falls on was no physic the fall. 2. All resident characteristic residents with assessed and plans were revito prevent/min. 3. The Nurse Eduservice to the iregarding care and update for repeat falls. 4. Unit charge nu	1/17/22. Care pand updated woroaches to addinimize recurrent 11/17/2022. The all injury as a rearts were review at the prior falls were all necessary of the prior falls were all necessary of the prior falls were all necessary of the prior falls were all necessary of the prior falls were all necessary of the prior falls were all necessary of the prior falls were fall the prior falls were fall the prior falls were fall the prior falls with the prior falls with the prior falls with repeated approaches and the prior falls with repeated approaches and the prior falls with repeated approaches and the prior falls with repeated approaches and the prior falls with repeated approaches and the prior falls with repeated approaches and the prior falls with repeated approaches and the prior falls with repeated approaches and the prior falls were falls with repeated approaches and the prior falls were falls with repeated approaches and the prior falls were falls with repeated approaches and the prior falls were falls were falls with repeated approaches and the prior falls were	olan vith dress nce of nere esult of ewed to alls. All e care goals els. d an in- y team nent v care t falls d

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	assessment reveale injuryContinue with level of care" 10/27/22 at 6:43 PM Fall)] " Fall Risk Sorepresents a high ris Score: 17 Indicate Continue current pla Care plan focus area on 10/27/22 due to p 10/28/22 had the approaches (occupational therap Encourage resident tight within reach." 11/02/22 at 3:21 PM (evaluation) & (and) walking" 11/04/22 at 4:32 PM Fall)] " Total Fall Ris Necessary Indicate Continue current plan 11/04/22 at 5:41 PM pm, resident was not (television) area Or verbally responsive, obleeding, swelling or Although Resident #6 was revised on 10/28 that facility staff failed approaches, actions,	If all Risk Assessment (Post core - Score of 10 or higher k for falls. Total Fall Risk care plan action taken. In of care." If all Risk Assessment (Post core - Score of 10 or higher k for falls. Total Fall Risk care plan action taken. In of care." If all Risk Assessment (Post core in a sistance and call core in a sistance and call in a sistance and call in a sistance in a sis	F	357			

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NAME OF F	ROVIDER OR SUPPLIER			1818 NEWTON ST. NW				
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F 657	Continued From page	e 49	F 6	Reside	ent #79			
	11/07/22 at 1:10 PM, Nursing/DON) acknow made no further commode no glassian state of the failure of the following no glassian state of the full no glassi	to revise Resident #79's a new dialysis access site. Idmitted to the facility on ses that included: Acute al Effusion and Chronic by Disease (COPD). 79's medical record in [Nursing Note] "Double on resident's right chest" order] "Resident is for any Wednesday, Friday" MDS dated 09/27/22 by ded: severe cognitive and dialysis while a resident. "[Resident #79] has ESRD ease) and is Hemodialysis		1. 2. 3.	Resident #79 was assessed DON on 11/4/2022. Resider not have any negative outco a result of this deficient practice care plan was updated on to address Dialysis access site. There were no negative outcome. All charts were reviewed to residents on dialysis. One additional resident on dialys assessed and care plan upon 11/4/22 to reflect new dialys access site and the association of the site. The nurse educator provide clinical care staff an in-servic comprehensive care planning care of resident on dialysis of 11/14/22. The Resident Care Coordinates designee) will review care president on dialysis monthly conduct weekly rounds to vecompliance with plan of care Findings will be reported to monthly. Completion date: Jan 9, 202 Nurse Educator	at did ome as office. 1/4/22 dentify is was lated on is ted care d all ce on g re: on ator (or ans of and crify e. QAPI		

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F 657	, ,		F 6	557			
	transparent pressure bleeding noted"	graft site] observed with dressing. No signs of					
	facility staff revised Re	ented evidence to show that esident #79's care plan to sis access site [left arm AV ted care of the site.					
	11/04/22 at 2:56 PM, Charge Nurse) stated updated to reflect both	interview conducted on Employee #10 (1st Floor , "It [care plan] needs to be n dialysis sites and care."					
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)(et Professional Standards i)	F6	58			
	§483.21(b)(3) Compre The services provided as outlined by the commust-	or arranged by the facility,					
	(i) Meet professional s	tandards of quality. is not met as evidenced			,		
	Based on observation (1) of 41 sampled residual	and staff interview, for one dents, facility staff failed to s within the professional Resident #99.					
	The findings included:						
	unacceptable because accurately be compare Administration Record least two of the seven	re-pouring medications is the medications: cannot ed to the Medications (MAR) and violates at rights of medication attent & right medication),					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ISTRUCTION	1 ' '	TE SURVEY MPLETED
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F 658	Continued From page medication errors"	51	F6		558 –Resident # 99 1. The Director of Nursing		
	medication errors" https://ceufast.com/cog-medication-pass During an observation 8:42 AM, Employee # Nurse) was observed that was located in the contained unwrapped to Resident #99. Empthe surveyor before shunidentified, loose tab was keeping the pills i give to the resident lat observed not performi directly touched the tabe given to the resident #99' herself, verifying the readdressing the resident did not inform Resider she was being administrated the "flat pills". Employed or assess the resident swallowing difficulties. In a face-to-face intervof observation, Employed.	ourse/long-term-care-nursin a on 11/09/22 starting at 13 (Licensed Practical retrieving a white paper cup e medication cart and loose tablets to administer loyee #13 was stopped by ne could administer the lets. The employee stated "I n the medication cart to eer. Employee #13 was ng hand hygiene and then blets that were intended to nt. Employee #13 then s room without identifying esident's identity, or nt by name. Employee #13 nt #99 of what medications stered. Resident #99 stated big pills" and can only take ee #13 did not acknowledge s concern with possible			 The Director of Nursing immediately provided Employee#13 a re-educat on medication administrat principles, residents rights and infection control procedures. There were n negative outcomes as a result of this deficient practice. Employee #13 attended 1:1 education withe Nurse Educator on 11/09/22. The nurse educator conducted random med pass observations for compliance with medication administration principles, residents rights and infect control (handwashing/han hygiene). 10 staff member who pass meds were observed and demonstrate compliance. All nursing staff were provided an in-service education on residents right and infection control principles (hand hygiene a hand washing). All license staff members who pass 	ion i, o th on d s ed	
	needed to say anything Resident #99 was adm 10/21/22, with multiple Dysphagia, Hypertens Gastro-Esophageal Re	nitted to the facility on diagnoses that included: ion, and			medications were provided an in-service on medication administration, resident's right, and infection control principles on 11/14/22 by the nurse educator/designee.	n	
	A review of the medica	if record revealed the		1	(on-going).		

	F CORRECTION	IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG		COMPLETED
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F 658	Continued From page	e 52	F6	Resident #99 continue	ed	
	following:			4. Adherence to me	edication	
	10/21/22 [physician's	Order] "Diet: Pureed"		administration pr hand hygiene wil	ll be	
		Minimum Data Set (MDS)]		monitored month nurse educator ti		
		e resident as having a Brief		weekly random		
		Status summary score of intact cognition; no rejection		observations. Sta		
		bited; holding food in mouth		violating these po will be provided r		
		od in mouth after meals;		education and	- C-	
	was I a mechanically	altered diet.		progressive disci	ipline.	
	11/01/22 [physician's	orderl "May crush		Finding will be re	ported to	
	medication and give in			QAPI monthly. 5 Completion date:	: Jan. 9,	
	administer Resident #	d that Employee #13 failed to 499's medications according ards of clinical practice.		2023 6. Nurse Educator		
	11/08/22 at 9:23 AM, Nursing) stated, "She	eceptor called out. We have ng, and I don't have a				
	Quality of Care		F 68	34		
SS=G	CFR(s): 483.25					
	applies to all treatmen facility residents. Base assessment of a resid that residents receive accordance with profe practice, the comprehe care plan, and the resi	ndamental principle that and care provided to ed on the comprehensive ent, the facility must ensure treatment and care in essional standards of ensive person-centered				

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	by: Based on observation interview, for two (2) of facility staff failed to expecience of the policy interview of the policy interview of the policy interviewed on 07/22/22 written by a licensed requiremental provided in the policy interviewed on 07/22/22 written by a licensed requiremental provided interviewed on 07/22/22 written by a licensed requiremental provided interviewed on 07/22/22 written by a licensed requiremental provided included description of skin arour was done as ordered feet even if no open an evidence of infection were reperformed in the policy in th	n, record review and staff of 41 sampled residents, insure that Resident #26 ment and care in accordance idards of practice and the her right foot; and facility Resident #32's skin every in Subsequently, the resident illulitis of left lower limb with individual that the resident remined that the resident's experience of the first observed on ined and resulted in 22. Documentation Criterial last directed, "Clinical notes are nurse in the medical record. It domly audited by registered fing of audit are reported to eart) team with scheduled es for decubitus/open of the area, size, necrotic tissue, and find the area treatment skin: note condition of reas existnote for" The shower book showed a Monitoring: CNA (Certified deport" that directed, ssment or a resident's skin	F	584	3. 3.	Resident #26 is no longer the facility. No corrective action can be done for this resident during this time frame. All residents with foot relat conditions will be assessed and care plan developed. A resident records were reviewed to identify resident with foot related conditions Care plan of 100% of residents with foot condition were revised to address for condition. No additional resident had any negative outcome as a result of this deficient practice. The Nurse Educator provided all interdisciplinary care plateam members an in-service on facility's comprehensive care plan policy on 11/14/2 (on-going). The Nursing Supervisor will review care plans developed for residents with foot related conditions monthly and reput to QAPI monthly. Completion date: January 92023 Director of Nursing	ed d All nts not led an ce ed ed ed ort	
		ssment or a resident's skin ent a shower. Report any						

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			WA	SHINGT	TON, DC 20010			
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immediately" The directed, "Charge is a designated space well as the charge of the control of	skin to the charge nurse e form also had an area that nurse assessment" followed by e for the CNA's signature as nurse's signature. ed to ensure that Resident #26 atment and care in accordance tandards of practice and the for her right foot. admitted to the facility on noses that included: Idiopathic mic Neuropathy, Type 2 and Muscle Weakness. t #26's medical record ing: n's order] "Monitor for every shift" as, "[Resident #26] is at risk for (related to) decreased ice, underweight" initiated on following approaches, "Report eakdown (sore, tender, red, or wide diet and supplement as insult PRN (as needed)Keep possible. Minimize skin	F	684	3- 1. 2. 3.	reviewed for skin monitoring shower reports to identify residents in need of skin assessment. Care plans of all residents in need of assessment were revised to reflect skin assessment policy. The Nurse Educator provided an in-service to all nursing staff regarding skin assessment and skin monitoring during showers on 11/14/22 (ongoing). Care plans will be monitored for implementation of interventions monthly by the DON/designee and findings will be reported to QAPI monthly. Individual care plans will be revised if needed, as determined by audit findings. Staff will be provided re-education and progressive discipline.			

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	no behavior issues of extensive assistance assist for bed mobility assistance with one putransfers, toilet use a functional limitations pressure ulcers; and or any other skin con 06/27/22 "Monthly Sumon new skin issues 07/14/22 at 11:48 AM"Pt's (patient's) nurs complained of big toe toe]Pt admits to doit the footPlan:Ord swelling) 0.6mg (millight, then 1 tablet 1 hou exacerbation." 07/14/22 at 10:55 PM (medical doctor) in ho (right) great toe swolld Colchicine 0.6mg tab 1 tab 1 hour later for 0 faxed, awaiting delived (plan of care)." 07/15/22 [physician's mg; amt (amount): 2 tall later for Gouty exacer It should be noted the receive Colchicine wa	refusal of care; required with two persons physical y; required extensive person physical assist for and personal hygiene; no in range of motion; at risk for no unhealed pressure ulcers ditions. I [Physician's Assistant Note] are reported that pt apain and redness [right and admits to pain to er Colchicine (decreases grams) tablet, give 2 tablet x ar later for Gouty [Nursing Note] "MD are, made aware of RT and aware of RT	F	84			

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	A review of the "1st F conducted and showe scheduled to receive Thursday evening shi CNA documentation sevening shift, Resider However, there was no report sheet was come assessment was perfect 11/09/22, facility staff documented evidence had been completed of her scheduled showed present. Treatment Administration that from 07/15/22 to 07/15/15/22 22 to 07/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/15/22 to 07/15/15/22 to 07/	door Assignment" sheet was a that Resident #26 was a shower every Monday and ft (3:00 PM - 11:00 PM). Showed that on 07/17/22, at #26 received a shower. To evidence that a skin pleted to show that a skin pleted to show that a skin prediction for the shower report sheet on Resident #26 for any of a days from January 2022 to the short and the shower report sheet on Resident #26 for any of a days from January 2022 to the short and the shower report sheet on Resident #26 for any of a days from January 2022 to the short and the shower report sheet on Resident #26 for any of a days from January 2022 to the short and shower report sheet on Resident #26 for any of a days from January 2022 to the shower sho	F	C 684	1. Resident # 26 is not the facility and not action can be done this timeframe. 2. All other residents breakdown were as as per facility policiplan revised to refleskin assessment policiensed nursing st regarding skin asses and timely physicia on resident's condi Nov. 14, 2022. 4. The wound care teassess residents whore we will be resident's physicial weekly. Care plans monitored for imple of interventions mothe DON/designee findings will be report QAPI monthly. 5. Completion date: Ja 2023 6. Director of Nursing	with skir ssessed y and ca ect week olicy. or vice to all aff essment in update tion from am will vith skin view skin/wour otification swill be ementation in thly by and orted to an.9,	e re cly n n n n n n n n n n n n n

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F 684	07/26/22 [physician's test that measures with test that measures with associates] "Uric Arange 2.3 - 6.6 mg/dL 07/28/22 at 8:11 AM "MSc (musculoskel motion) to lower extrediscoloration of the foredemaPlan 1. Conting plan and level of care medication regimen at 07/31/22 [Monthly Surecently completed arcellulitis" 08/01/22 at 10:06 PM [resident's] RT foot repain." 08/06/22 at 7:34 PM [done regarding PVD (Disease) with dry gan persists with skin warrange continue current treat A Quarterly MDS date staff coded: required extensive assist for per pressure ulcers; and 10 present.	order] "Uric Acid" [laboratory aste product found in blood] [American Health cid 3.9 Reference . (deciliter)" [Physician's Assistant Note] etal): Normal ROM (range of emities, hyper pigmented tot, and no pedal inue with current treatment Continue with Cellulitis and treatment." In the state of th	F	584	D-1. 1. 2. 3. 4. 5. 6.	Resident # 26 is no lin the facility and no corrective action can done during this timeframe. All other residents rewere reviewed for incomplete duplex/vastudies and followed through as needed. Were no other vascular/duplex studies time. Inservice was provided all licensed nursing stregarding timely implementation of physician's orders by nurse educator. Uncompleted orders referred to the physic Inservice was provided the DON on 11/11/22 Resident care coordined will monitor timely completion of consult orders weekly and recompletion date: Jar 2023 Director of Nursing	be cords ascular There ies at ed to staff will be sian. ed by 2. nators	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY	
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F 684	Resident having 1 ver However, there are no assessments/clinical wound/ulcer for this till Care plan focus area,	nous/arterial ulcer present. o documented skin notes for any open me period. "[Resident #26] is at risk for	F€	384	 Resident # 32 was assessed DON on 11/4/2022. Treatment order for Res. #32's left leg voltained on 11/4/2022. Care was updated on 11/4/2022. All other residents' skin asse 	ent was e plan essment		
	underweight" show 08/16/22. However, the when facility staff first condition to the reside plan was updated to in care goals and approximately show the care goals and approximately show the care goals and approximately show the care goals and approximately show the care goals and approximately show the care goals and approximately show the care goals and approximately show the care goals and approximately show the care goals are careful to the care goals and approximately show the careful to the care goals are careful to the careful to	nere was no evidence that noted the change in the ent's right foot, that the care include person-centered aches that addressed rocedures, or activities for			was done, and care plans re to reflect facility's policy on s assessment. 3. The Nurse Educator provide service on the importance of thorough skin assessment a developing care plans from 11/14/2022. The nurse educ reviewed the skin assessme policy with the nursing staff.	care plans revised s policy on skin eator provided an in apportance of a seessment and plans from an urse educator an assessment ursing staff.		
	Resident #26 having of 08/23/22 (15 days), the evidence that facility is assessment (skin colors swelling) of Resident #2 The August 2022 TAR to 08/23/22 (15 days), "0" or "none noted" in "Monitor for bruising/b that Resident #26 was (every) 2 hours". 08/24/22 at 9:56 PM [N Consult for RT lower examines the blood floweins in the arms and lup. DX (diagnosis) (1) Wound great toe RT needs was needed.	r, temperature, pain and #26's right foot. showed that from 08/09/22 facility staff documented: the area that directed, leeding every shift"; and "turned and repositioned q "ursing Note] "Vascular xtremity. [Duplex (test w in the major arteries and legs)] for diagnosis follow Toe pain great toe (2) acrotic (sp). (2) Wound at toe and light dressing			 4. Skin assessment documents and care plan will be reviewed the DON/designee. Findings reported to QAPI quarterly. 5. Completion date: Jan. 9, 202 6. Director of Nursing 	ed by will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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STODDARD BAPTIST NURSING HOME				1818 NEWTON ST. NW WASHINGTON, DC 20010			
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	08/24/22 [physician's rt lower extremity [Du follow up" 08/24/22 [physician's cleansing RT great to vascular consult - onc 09/03/22 at 1:00 PM [today by wound docto 09/03/22 [physician's antibacterial) ointment to open to air dry" 09/08/22 at 11:02 AM "Pt seen at bedside or and stable Pt appeadenies to pain to the follower extremities, hyp of the foot, and no per current treatment and From 09/09/22 to 09/2 no documented evider performed an assessment temperature, pain and right foot.	order] "Vascular consult for plex] for diagnosis and order] "Wound care e and light dressing pending e a day" Nursing Note] "Seen or" order] "Bacitracin (topical topical 6					
	once daily. Leave oper that the task was comp or "none noted" in the for bruising/bleeding e	n to air dry" indicating bleted and documented: "0" area that directed, "Monitor					

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"Pt's nurse reported the changing color with grommunicated through bilateral duplex arterial rule out occlusion." 09/23/22 [physician's arterial/venous right lead of the called that Dog and not today, to be decomposed of the venous ultrasound venous clot" 09/26/22 at 2:54 PM [I #26] was seen today to the wound team in hot perfusing (sp) right to the continue Bacitracing to air No new order at 09/29/22 at 6:35 PM [I "Pt's nurse reported the results that need to be Imaging: Venous Dog extremities) shows no Plan Continue with colevel of care"	nat pt's right foot toes are angrene Pt was h phone translator Order al/venous US (ultrasound) to order] "Duplex Doppler eg and left leg" [Nursing Note] "Dynamic opler will be done tomorrow one on 09/24/22" Dynamic Mobile Imaging oppler bilateral findings: is normalno evidence of the eywound specialist and use for dry gangrene es ischemic 1st, 4th and 5th in ointment and leave open at this time." Physician's AssistantNote] at pt had Doppler Scan reviewed and addressed oppler bilateral LE (lower evidence of venous clots urrent treatment plan and order] "Bilateral lower					
10/01/22 at 10:00 PM	[Nursing Note] "Total care					
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H SUMMARY ST. (EACH DEFICIENCY REGULATORY OR I Continued From page 09/22/22 at 7:34 PM ["Pt's nurse reported the changing color with gate communicated through bilateral duplex arterial rule out occlusion." 09/23/22 [physician's arterial/wenous right left of the color of the venous ultrasound venous clot" 09/24/22 at 9:20 PM " procedure: venous Do the venous ultrasound venous clot" 09/26/22 at 2:54 PM [I #26] was seen today be the wound team in how perfusing (sp) right toe continue Bacitracing to air No new order at the color of the venous clot in the color of the venous clot in the color of the venous clot in the wound team in how perfusing (sp) right toe continue Bacitracing to air No new order at the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the color of the venous clot in the venous cl	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 60 09/22/22 at 7:34 PM [Physician's Assistant Note] "Pt's nurse reported that pt's right foot toes are changing color with gangrene Pt was communicated through phone translator Order bilateral duplex arterial/venous US (ultrasound) to rule out occlusion." 09/23/22 [physician's order] "Duplex Doppler arterial/venous right leg and left leg" 09/23/22 at 11:24 PM [Nursing Note] "Dynamic mobile called that Doppler will be done tomorrow and not today, to be done on 09/24/22" 09/24/22 at 9:20 PM "Dynamic Mobile Imaging procedure: venous Doppler bilateral findings: the venous ultrasound is normalno evidence of venous clot" 09/26/22 at 2:54 PM [Nursing Note] "[Resident #26] was seen today bywound specialist and the wound team in house for dry gangrene perfusing (sp) right toes ischemic 1st, 4th and 5th toe continue Bacitracin ointment and leave open to air No new order at this time." 09/29/22 at 6:35 PM [Physician's AssistantNote] "Pt's nurse reported that pt had Doppler Scan results that need to be reviewed and addressed Imaging: Venous Doppler bilateral LE (lower extremities) shows no evidence of venous clotsPlan Continue with current treatment plan and	ROVIDER OR SUPPLIER RD BAPTIST NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 60 09/22/22 at 7:34 PM [Physician's Assistant Note] "Pt's nurse reported that pt's right foot toes are changing color with gangrene Pt was communicated through phone translator Order bilateral duplex arterial/venous US (ultrasound) to rule out occlusion." 09/23/22 [physician's order] "Duplex Doppler arteriallvenous right leg and left leg" 09/23/22 at 11:24 PM [Nursing Note] "Dynamic mobile called that Doppler will be done tomorrow and not today, to be done on 09/24/22" 09/24/22 at 9:20 PM "Dynamic Mobile Imaging procedure: venous Doppler bilateral findings: the venous ultrasound is normalno evidence of venous clot" 09/26/22 at 2:54 PM [Nursing Note] "[Resident #26] was seen today bywound specialist and the wound team in house for dry gangrene perfusing (sp) right toes ischemic 1st, 4th and 5th toe continue Bacitracin ointment and leave open to air No new order at this time." 09/29/22 at 6:35 PM [Physician's AssistantNote] "Pt's nurse reported that pt had Doppler Scan results that need to be reviewed and addressed Imaging: Venous Doppler bilateral LE (lower extremities) shows no evidence of venous clotsPlan Continue with current treatment plan and level of care" 10/01/22 [physician's order] "Bilateral lower extremities arterial Doppler"	ROVIDER OR SUPPLIER RD BAPTIST NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 60 F 684 O9/22/22 at 7:34 PM [Physician's Assistant Note] "Pt's nurse reported that pt's right foot toes are changing color with gangrene Pt was communicated through phone translator Order bilateral duplex arterial/venous US (ultrasound) to rule out occlusion." O9/23/22 [physician's order] "Duplex Doppler arteriallvenous right leg and left leg" O9/23/22 at 11:24 PM [Nursing Note] "Dynamic mobile called that Doppler will be done tomorrow and not today, to be done on 09/24/22" O9/24/22 at 9:20 PM "Dynamic Mobile Imaging procedure: venous Doppler bilateral findings: the venous ultrasound is normal no evidence of venous clot" O9/26/22 at 2:54 PM [Nursing Note] "[Resident #26] was seen today bywound specialist and the wound team in house for dry gangrene perfusing (sp) right toes ischemic 1st, 4th and 5th toe continue Bacitracin ointment and leave open to air No new order at this time." 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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		095020	B. WING _			11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAF	RD BAPTIST NURSING H	OME			818 NEWTON ST. NW		*
				V	VASHINGTON, DC 20010		
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F 684	Continued From page	· 61	F6	384			
	, -	repositioned [every] 2 hours					
		emities arterial Doppler					
	done this shift, result p	pending"					
	10/02/22 at 1:06 AM I	Dynamic Mobile Imaging]					
		legs bilateral venous					
	•	ate plaque is noted within					
		Findings consistent with					
		t occlusion, right lower					
		stenosis between right y and mid SFA (superficial					
	•	rate stenosis of the right					
	distal SFA"	Q					
	14 - h l - l - h 4 h 4	t the advantage to the Cont					
		t the duplex test was first A venous duplex test was					
		/24/22 (31 days later), that					
	*	of venous clots. Within this					
	* ·	#26 had additional toes that					
	•	and 5th toes). An arterial on 10/01/22 that showed					
	•	enosis of the right lower					
	extremity.	should of the fight lower					
	·						
	The October 2022 TAP						
		facility staff initialed in the citracinapply ointment to					
I	right toe once daily. Le		•			i	
	indicating that the task	was completed and		1			
,		one noted" in the area that				ĺ	
	directed, "Monitor for b						
	snift"; and that Resider repositioned q (every)	nt #26 was "turned and 2 hours"					
	repositioned q (every)	m nould .					
E .		6/22, (15 days), there was					
	no documented eviden						
	performed an assessm			1			
	temperature, pain and right foot.	swelling) of Resident #26's					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		095020	B. WING_			C 11/09/2022
	ROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, 1818 NEWTON ST. NW WASHINGTON, DC 20010	ZIP CODE	1110012022
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F 684	Continued From page	e 62	F 6	684		
	#26] was seen today the wound team in ho perfusing right toes is	Nursing Note] "[Resident bywound specialist and use for dry gangrene chemic 1st, 4th and 5th to ntment and leave open to				
	seen by PCP (prima					
	with dry gangrene of [surgery, no urgent sur	O (emergency department) right] foot Per vascular rgical intervention is recommended Betadine				
	back on the unit from lat 3:45pm Resident recommendation for ritreatment with Betadin	ne daily and to follow up with cheduled vascular surgery				
		order] "Cleanse right foot se and leave open to air				
	presents with gangren extending to the midfo healing The only che	ot no realistic chance of oice her would be n The patient and family				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG			E SURVEY PLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 1818 NEWTON ST. NW WASHINGTON, DC 20			109/2022
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F 684	Continued From pag	e 63	F6	84			
	PM, Resident #26 wa with a sheet, with bot right foot was observ	st floor on 10/31/22 at 12:15 as observed in bed, covered th her feet exposed. The ed to be necrotic from xtending to all five of her					
	plan showed that from was no evidence that patient-centered care	26's comprehensive care n 07/14/22 to 11/03/22there facility staff developed a plan with goals, ss care of Resident #26's					
	Resident #26 with the	ce that facility staff provided enecessary care and neet the resident's needs as					
	A. Failure to develop to address care of Re	a patient-centered care plan sident #26's right foot					
		ongoing skin assessments ility's policies and "Skin eport"					
	temperature, pain and right foot in order repo deterioration in the re- physician from 07/15/ 08/09/22 to 08/23/22	and document skin color, I swelling of Resident #26's ort any changes and sidents condition to the 22 to 07/22/22 (8 days), (15 days), 09/09/22 to d 10/02/22 to 10/16/22 (15					
	consult in a timely ma	dered duplex and vascular nner. Duplex and Vascular on 08/24/22. A venous					e vision con a construction of the constructio

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1818 NEWTON ST. NW WASHINGTON, DC 20010)E	11/03/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 684	duplex test was not co (totaling 31 days later of venous clots. Within Resident #26 had addischemic (1st, 4th and duplex was then done PVD with moderate sextremity. The vascul on 10/26/22 (totaling documented, "gangre extending to the midfor healingThe only che below-knee amputation. The only che below-knee amputation. During a face-to-face 12:21 PM, Employee Nurse) reviewed Resi care plan, acknowled no further comments. During a face-to-face 11/07/22 at 12:09 PM "When the doctor's or reviews it and lets the can be scheduled. On arrangements are mathe consult date is downly Resident #26's vascheduled as ordered don't know." A face-to-face interview of Nursing/DON) and Employee #11 stated, do a weekly skin asse whether they have wo	ompleted until 09/24/22 c), that showed no evidence in this timeframe (31 days), ditional toes that became d 5th toes). An arterial e on 10/01/22 that showed tenosis of the right lower ar consult was completed 63 days later) where it was ne of the right foot bot no realistic chance of bice [for] her would be on" interview on 11/04/22 at #10 (1st Floor Charge dent #26's comprehensive ged the findings, and made interview conducted on , Employee #10 stated, der a consult, the nurse unit secretary know so it ice it is scheduled, de for transportation and cumented." When asked ascular consult was never , the employee stated, "I w was conducted on with Employees #2 (Director #11 (Clinical Educator). "Nurses are supposed to ssment on all residents unds or not. When the they look for any new areas	F6	584		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N	IIIMBED.	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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09502	20 B. WING		11/09/2022	
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
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documents it in Matrix Care (facility's ele health record system) and makes the do aware. There's a shower sheet that both and nurse have to sign off on. The show are kept in a binder. There's one for eve When asked who audits the shower she Matrix Care to ensure compliance with riskin assessments, Employee #11 stated answer that question." Employee #2 stated, "Unit Managers are supposed to check that the shower shee weekly skin assessments are being done report back to me. There have not been audits done lately on whether the skin assessments are being completed and I audited or reviewed to make sure that the [shower report] are getting completed." Vasked about the care plans either not ge developed or not being patient-centered, Employee #2 stated, "Only the RNs (reginurses) can start or revise care plans. The charge nurses, evening and night supervand myself." Employee #2 acknowledged licensed staff have not been developing revising the care plans with patient-centered and approaches. When asked abo facility's process is for when the physicial laboratory (lab) or any other test. Employ stated, "If the doctor orders a test, we can or the x-ray and tell them. Once the result we call the doctor and make him aware or results. The nurse then signs and dates the and puts it in the doctor's binder for them when they come in. The night shift is suppicheck to see if tests that were ordered we obtained, if the results are back and if the reported to the physician." When asked a delay of Resident #26's ordered duplex te	ectronic octor In the CNA over sheets In y unit." I ets or I esident I, "I can't I can	684		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED
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	Employee #2 stated to was missed the first to During a face-to-face 11/09/22 at 11:08 AM (Director of Quality Imaware of the findings receive the necessary for her right foot, caus They all acknowledge 2. Facility staff failed to skin every shift per the the resident was obselower limb with edema During an observation at 3:41 PM, Resident had started to swell ar She said she had comtime but believed they laundry to be cleaned surveyor noted that the edematous from the konthe resident's leg apareas at the outer kne that no facility staff had she had not mentioned Resident #32 was adm 06/17/21 with diagnosi Vascular Disease, Cel Limb, Diabetes Mellitu Leg below the Knee. Review of Resident #3 revealed:	interview conducted on provement) were made that Resident #26 did not care and required services ing a negative outcome. It defines that Resident #32's exact plan. Subsequently, revel with cellulitis of left and interview on 11/01/22 #32 stated that her left leg and would sometimes leak. It is pression stockings at one were taken with her and never replaced. The exident's left leg was nee to the ankle. The skin opeared dark with light pink exident also stated if looked at her leg because including Peripheral lulitis of the Left Lowers, and Absence of Right	F	584		

*	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP 1818 NEWTON ST. NW WASHINGTON, DC 20010	CODE	11/03/2022
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	for Bruising/Bleeding 06/17/21 at 8:46 PM: "Emollient topical lotic for dry skin." Care plan initiated on integrity[Resident # breakdown r/t (related cellulitis Approach: A presence of risk factor possible Report any (sore, tender, red or b shift" 05/14/22 at 2:55 PM [wrap with non-stretch venous insufficiency." A Quarterly MDS date facility staff coded: a E Status (BIMS)Summa intact cognition; requir bed mobility, transfers dressing, toilet use, perfunctional impairment extremity; and was at ulcers. 09/19/22 at 1:45 PM [I " Complaint of drynes leg ordered Furosem Spironolactone 25 mg edema caused by fluic advised to continue the topical lotion) for drynes	[physician's order]: on, apply 2x/day as needed 01/10/22: "Category: Skin d to) lower extremity Assess Resident for the rsKeep clean and dry as r signs of skin breakdown broken areas), skin every physician's order]: "Leg leg wrap daily to left leg for d 08/11/22 showed that Brief Interview for Mental rry Score of "15," indicating red extensive assistance for red extensive assistance for red extensive assistance for red extensive pathing; on one side for lower risk for developing pressure Nursing Progress Note]: as and scaling of the left ide 40 mg (milligrams) and once a day (to reduce d accumulation). Also e use of Cetaphil (emollient less of the leg"	F6	684		

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	that facility staff initials "Monitor[ed] for bruising applied "leg wrap with to left leg for venous in the left leg for venous in the left leg for venous in the left leg for venous in the facility staff initials "emollient topical lotion of the left lower extremity to pain and swelling in our changes and deteriors." During a face-to-face in 11/07/22 at 1:10 PM, in Nursing/DON) acknown made no further common the licensed assessments, they show skin areas and the containing a face-to-face in 3:30 PM, Employee #7 reviewed the findings in that when the licensed assessments, they show skin areas and the containing a face-to-face in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in 11/09/22 at 11:08 AM, (Director of Quality Improved in the licensed in th	loration to left ss skin every shift" D3/22, Resident #32's tion Record (TAR) showed ed to attest that they ng/bleeding every shift" and non-stretch leg wrap daily nsufficiency". D3/22, Resident #32's tion Record (MAR) showed ed to attest that they applied on 2x/day for dry skin". D3/22 (45 days), there was thy staff implemented a daily condition of Resident #32's include color, temperature, reder to identify and report ation. Interview conducted on Employee #2 (Director of reledged the finding and ments. Interview on 11/07/22 at I1 (Clinical Educator) For Resident #32 and stated nurses do the skin could document the any new addition of the other existing	F	84		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		11/05/2022
070004	DD DADTIOT WIDOWO	OMP		1818 NEWTON ST. NW		
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F 684	Continued From page	e 69	F 684	F 686 – Resident #350		
	assess Resident #32' resident's comprehen acknowledged the fin	sive care plan and they all dings.		 Resident #350 is no longer in the facility to actively correct the deficiency. All other residents 	ı	
	l .	event/Heal PressureUlcer i)(ii)	F 686	2. All other residents received skin assessments. No additional residents hany negative outcome		
	§483.25(b)(1) Pressuing Based on the compression of the facility of the facili	re ulcers. hensive assessment of a ust ensure that- care, consistent with s of practice, to prevent bes not develop pressure vidual's clinical condition y were unavoidable; and ssure ulcers receives and services, consistent dards of practice, to ent infection and prevent oping. is not met as evidenced ew and staff interviews, for residents, facility staff esidents received care to f existing pressure ulcers		a result of this deficie practice. 3. The nurse educator provided all licensed san in-service on skin assessment documentation and caplanning from 11/14/2 (on-going). 4. The DON/designee w conduct weekly audits skin assessments and plan of care. Discrepancies betwee plan of care and assessment documentation will be corrected and reporte QAPI monthly. 5. Completion date: Jan 2023 6. Director of nursing	ent staff are 022 ill s of I	
	Resident #350 was ad admitted 10/23/19 with	mitted to the facility				

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	Disease, Dysphagia, Extremity Contracture Weakness. A complaint, DC0001 Agency on 12/30/21 C Social Worker] expla asked her to file a repthe pressure wounds niece who also wante (attach). Since, both [niece wanted to file a condition of and care receiving, our office is together to your office as appropriate." A review of Resident revealed: 10/23/19 at 11:59 AM barrier cream to sacruafter each incontinent 10/24/19 at 12:16 PM for Bruising/Bleeding of 10/24/19 at 12:16 PM and Repositioning Q (09/08/21 [Care Plan]: [Resident #350] has p skin integrity, r/t (related diseaseApproach: "A and note any changes Quarterly Minimum Date 2000 and 2	Gastrostomy Status, Lower and Generalized Muscle 0482, received by the State documented, "[Hospital ined that the physician for due to the condition of and call was placed to the dot file a complaint Local Hospital] and the complaint about the that the member was a submitting the complaints for review and investigation #350's medical record [physician's order]: "Apply m, buttocks, and peri-area care for skin protection." [physician's order]: "Monitor every shift." [physician's order]: "Turn every) 2 hours." "Category: Skin Integrity otential for impairment of ed to) peripheral vascular Assess skin condition daily" ata Set dated 09/30/21 aded: extensive assistance	F	886			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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NAME OF D	ROVIDER OR SUPPLIER	055020	D. WING _		STREET ADDRESS, CITY, STATE, ZIP CODE	11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER				818 NEWTON ST. NW		
STODDAF	RD BAPTIST NURSING H	OME			VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	· 71	F6	886			
	dressing, bathing, and addition, facility staff of having no pressure ultimated arterial ulcers; an pressure ulcers/injuried 12/06/21 at 3:00 PM [observed with [an] intermeasuring 3 cm (cent shift. PMD (Primary Manufacture)]	ers, locomotion, toileting, dipersonal hygiene. In coded the Resident as cers, having two venous id at risk for developing es. Nursing Progress Note]: " act blister in the sacrum imeter) x 3.5 cm x 0 cm this ledical Doctor) made aware use the area with normal					
	saline, apply bacitraci air until seen by woun	n ointment and leave open d doctor"					
	initial skin sheet: intac Assessment: Weekly Stage: Pressure ulcer Blister, Appearance: C	Skin Sheet]: "Description It sacral blister, Type of Skin SkinLocation: Sacrum, Stage 2, Type of Wound: Clean, Drainage: None th: 3.5 cm, Depth: 0 cm."					
		12/06/21: "Category Assess skin condition daily , treatment as indicated"					
	was no documented e	9/21 (three days), there vidence that facility staff 50's sacral area or skin		-			
	(TAR) showed that froi facility staff initialed to applying barrier cream buttocks, and peri-area care for skin protection skin for bruising and bi	to the resident's sacrum, a after each incontinent n; monitoring the resident's					

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED		
							С
		095020	B. WING			11	/09/2022
	ROVIDER OR SUPPLIER D BAPTIST NURSING H	OME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	"Resident seen today Physician]/wound tear assessment and evaluscabs and sacral intact bilateral leg scabs, dry 12/11/21 - there was rethat facility staff assessarea. 12/11/21 Treatment Assowed facility staff in were: applying barrier sacrum, buttocks, and incontinent care for skethe resident's skin for the shift and were turning resident every two house 12/11/21, facility staff in were cleansing Resident every two house 12/11/21, facility staff in were cleansing Resident every two house 12/11/21 at 2:36 PM [Strate of the property of t	I [Nursing Progress Nurse]: by [Wound Care m during wound rounds for uation of bilateral leg dry bilister. Upon assessment, and stable" no documented evidence sed Resident #350's sacral dministrated Record (TAR) itialed to attest that they cream to the resident's peri-area after each in protection; monitoring bruising and bleeding every and repositioning the urs. cation Administration of that from 12/06/21 to nitialed to attest that they ent #350's sacral blister with g Bacitracin ointment, and Skin Sheet]: "Description is sacral blister, Type of Skin	F	686			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
					С	
		095020	B. WING		11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAF	RD BAPTIST NURSING H	OME		1818 NEWTON ST. NW		
				WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 686	(Nurse Practitioner) blister. New order to c	and he was made aware of clean area with normal	F 68	6		
	until seen by [Wound					
	resident's sacrum from (three days) and on 12 12/12/21, the resident	ce that facility staff y skin assessments on the n 12/07/21 to 12/09/21 2/11/21. Subsequently, on the developed a new blister on as first observed measuring				
	3:30 PM, Employee # reviewed the findings that when the licensed assessments, they sho skin areas and the cor areas. When asked if ulcers are part of that,	for Resident #350 stated I nurse do the skin ould document the any new ndition of the other existing				
	Cross reference DCMI Free of Accident Haza CFR(s): 483.25(d)(1)(2	rds/Supervision/Devices	F 689			
		re that - ident environment remains cards as is possible; and				
	supervision and assist accidents.	ident receives adequate ance devices to prevent is not met as evidenced				

	OF DEFICIENCIES CORRECTION	DECTION IDENTIFICATION NUMBER				(X2) MULTIPLE CONSTRUCTION A. BUILDING				
			A. BOILDII	NG _		1440-4-1-0-1-0-1-0-1-0-1-0-1-0-1-0-1-0-1		С		
		095020	B. WING_					/09/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADD	RESS, CITY, STATE, ZIP CODE				
STODDAR	RD BAPTIST NURSING H	OME		1	818 NEWTO	ON ST. NW				
310000	CD DAI 1131 NOROING 11			٧	VASHINGT	TON, DC 20010				
(X4) ID		ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION		
PREFIX TAG		/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	Κ.		(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA		DATE		
						DEFICIENCY)				
					F 689 -	- Resident #80 and #68				
F 689			F6	889						
		ew and staff interview, for			1.	Residents #80 and 68 were	9			
	to identify and implem	resident, facility staff failed				assessed by the DON on				
		the risk of accidents (falls).				11/18/22022. Both resident	S			
	Residents' #80 and #6	, ,				had repeat falls. Both residents' care plans were				
						updated, Resident #68 was	3			
	The findings included:	:				updated on 11/18 and Res				
	1 Excility staff failed t	o identify and implement				was updated on 12/27 to				
		hes to reduce the risk of				reflect additional approache	es			
		d multiple falls having an				to address				
	injury of unknown orig					prevention/minimize recurrence.				
			2. All other residents were							
	Resident #80 was adr					assessed for potential for fa	alls.			
	Cerebrovascular Accid	diagnoses that included:				Care plans of residents with				
		pertension, and Respiratory				repeat falls were updated for	or			
	Distress.	,				additional approaches to prevent/minimize repeat fal	le.			
					3	The Nurse Educator provid				
	Review of Resident #8				0.	an in-service to the	-			
	revealed the following	;				interdisciplinary team				
	A Quarterly Minimum	Data Set (MDS) dated				regarding care plan				
	02/14/22 showed facil					development and update for	r			
		tatus (BIMS) summary			Λ	residents with repeat falls. Unit charge nurses will revi	ων.			
		g intact cognition and used			╼.	care plans of residents with				
	a wheelchair for mobil	ity.				repeat falls for additional				
						approaches and interventio				
	03/21/22 at 4:30 PM [Nurses Progress Note]				weekly until 100% complian				
		charge nurse and other				is achieved and sustained f				
		pped from her wheelchair				3 months. This will be report to QAPI monthly.	icu			
i i	· ·	hen asked what happened			5.	Completion date: Jan 9, 202	23			
	the other side and I sli	ust wanted to shift myself to			6.	•				
		edical doctor) and POC				-				
	(point of contact) made									
	-			1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С
		095020	B. WING	 	11/09/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
0.7.0.0.0.4.5	D DARTIOT MURAINO U	OME		1818 NEWTON ST. NW	
STODDAR	RD BAPTIST NURSING H	OME		WASHINGTON, DC 20010	
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D.4.77
F 689	Continued From page	e 75	F 68	9	
	"Category Falls" [Res for falls R/T [related to extremity weakness reminders not to ambi assistance, keep call times. Encourage resi when needed. Provide needed during all shift frequently used items lowest position." There was no evidence patient-centered care	light within reach at all idents to use call lights e toileting assistance as its. Keep personal items and within reachbed in the			
	dated 05/02/22, show Brief Interview for Mer score of "3", indicating impairment; required of two person physical as	Minimum Data Set (MDS) ed that facility staff coded: a ntal Status (BIMS) summary g severe cognitive extensive assistance with ssist for bed mobility,			
	physical assist for persimpairments in range	d toilet use; one person sonal hygiene; no functional of motion; no falls since -entry or prior assessment.			
	"writer's attention was to resident who was sa room. When asked wh stated "I wanted to go from my bed When as assistance, she kept mesident was found lyinhead upright, alert and	to the bathroom and I fell ked why she didn't call for nute. On Assessment, ng beside her bed with I oriented x2 MD notified lent be monitored closely			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		095020	B. WING _			1	C /09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING F	IOME		STREET ADDRESS, CITY, STATE, Z 1818 NEWTON ST. NW WASHINGTON, DC 20010	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE, CROSS-REFERENCED DEFICI	ACTION SHOULD B TO THE APPROPRI		(X5) COMPLETION DATE
F 689	Continued From page	e 76	F 6	889			
	Nursing will continue A Facility Reported In received on 05/21/22 writer was called by owith a swollen area of unknown origin. On a soft to touch and nor area observed no pai Resident is alert and confusion. When aske was unable to explain visit and was notified. called"	documented, "At 6:50 PM sharge nurse to see resident in her left side of forehead of ssessment, the area was tender, no bruises or open in on touching the area, responsive with intermittent ed what happened. Resident in POC was on the unit to MD (medical doctor) was					
		ent #80 to prevent further she had a fall on 05/15/22. R 3211.1					
		o identify and implement nes to reduce the risk of an accident (fall).					
	Resident #68 was adr 06/17/22 with multiple Difficulty in Walking, N Other Abnormalities o	diagnoses that included: luscle Weakness and					
4	Review of Resident #6 revealed the following						
	pm, attention drawn by	as said to have fallen by the					

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDII		(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID PREFIX (EACH DEPICIENCY MUST BE PRECORDED BY FULL TAGS) REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 77 resident could not explain but roommate said he was walking round the room and tripped." Care plan focus area "[Resident #68] had a fall on 7728/22 due to poor judgment/disease process" initiated on 07/28/22 had the approaches of, "PT (physical therapy)/CT (occupational therapy) consult PRN (as needed). Encourage resident to ask for assistance and call light within reach." A Quarterly Minimum Data Set (MDS) dated 09/15/22 showed facility staff documented: vision adequate, no corrective lenses; moderately impaired cognition; required extensive assistance with one person physical assist for bed mobility, transfers; balance during moving from seated to standing was not steady, only able to stabilize with staff assistance; functional impairment in range of motion on one side for lower extremities; used a walker and wheelchair for mobility, no falls since admission/reentry or prior assessment; and received restorative nursing in transfer and walking. 10/27/22 at 1.45 PM [Physician's Assistant Note] "[Recorded as Late Entry on 10/28/2020.212 PM] Pt's nurse reported that pt had a fall and general assessment revealed no physical injury Continue with current treatment plan and level of care" 10/27/22 at 6:43 PM [Fall Risk Assessment (Post								С
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY WAS THE PRECEDED BY PILL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MAST BE PRECEDED BY PILL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORR			095020	B. WING_			11	/09/2022
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 77 resident could not explain but roommate said he was walking round the room and tripped." Care plan focus area "[Resident #88] had a fall on 7/28/22 due to poor judgment/disease process" initiated on 07/28/22 had the approaches of, "PT (physical therapy)/OT (occupational therapy) consult PRN (as needed). Encourage resident to ask for assistance and call light within reach." A Quarterly Minimum Data Set (MDS) dated 09/15/22 showed facility staff documented: vision adequate, no corrective lenses; moderately impaired cognition, required extensive assistance with one person physical assist for bed mobility, transfers; balance during moving from seated to standing was not steady, only able to stabilize with staff assistance, functional impairment in range of motion on one side for lower extremities; used a walker and wheelchair for mobility, no falls since admission/reentry or prior assessment; and received restorative nursing in transfer and walking. 10/27/22 at 1:45 PM [Physician's Assistant Note] "[Recorded as Late Entry on 10/28/2022 02:12 PM] Pts nurse reported that pt had a fall and general assessment revealed no physical injury Continue with current treatment plan and level of care"			OME		1	818 NEWTON ST. NW		
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represents a high risk for falls. Total Fall Risk Score: 17 Indicate care plan action taken. Continue current plan of care." Care plan focus area, "[Resident #68] had a fall on 10/27/22 due to poor judgment" initiated on		resident could not exp was walking round the Care plan focus area 7/28/22 due to poor juinitiated on 07/28/22 l (physical therapy)/OT consult PRN (as need ask for assistance and A Quarterly Minimum 09/15/22 showed facil adequate, no correctivimpaired cognition; re with one person physitransfers; balance dur standing was not stea with staff assistance; range of motion on on used a walker and whis since admission/reent received restorative now walking. 10/27/22 at 1:45 PM [I "[Recorded as Late Er PM] Pt's nurse reported general assessment recontinue with current care" 10/27/22 at 6:43 PM [I Fall)] " Fall Risk Scorepresents a high risk Score: 17 Indicate ca Continue current plan Care plan focus area,	plain but roommate said here room and tripped." "[Resident #68] had a fall on udgment/disease process" and the approaches of, " PT of (occupational therapy) and the approaches of, " PT of (occupational therapy) and the approaches of, " PT of (occupational therapy) and call light within reach." Data Set (MDS) dated a lity staff documented: vision are lenses; moderately quired extensive assistance assist for bed mobility, and moving from seated to addy, only able to stabilize functional impairment in the side for lower extremities; eelchair for mobility; no falls ary or prior assessment; and ursing in transfer and Physician's Assistant Note] and the physician's Assistant Note, and the physician's Assistant Note, and the physician's Assistant Note, and the physician's Assistant Note, and the physician's Assistant Note, and the physician's Assistant Note, and the physician's Assista	F6	389			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
	095020	B. WING			C 11/09/2022
	HOME		STREET ADDRESS, CITY, STATE, Z 1818 NEWTON ST. NW WASHINGTON, DC 20010	ZIP CODE	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED 1	ACTION SHOULD B TO THE APPROPRI	
10/28/22 had the approaches of Encourage resident to light within reach." 11/02/22 at 3:21 PM (evaluation) & (and) to walking" 11/04/22 at 4:32 PM Fall)] "Total Fall Rist Necessary Indicate Continue current plant 11/04/22 at 5:41 PM pm, resident was note (television) areaOn verbally responsive, or bleeding, swelling or state that the resident sustained buring a face-to-face 11/07/22 at 1:10 PM, Nursing/DON) was mader findings and made Cross reference DCM Dialysis CFR(s): 483.25(l) S483.25(l) Dialysis. The facility must ensu	of, "PT/OT consult PRN. o ask for assistance and call [physician's order] "PT eval reatto address difficulty in [Fall Risk Assessment (Post ik Score: 17No Referrals e care plan action taken. of care." [Nursing Note] "At 3:20 ed with a fall at the TV assessment: alert and wriented x 1(self), no bruises, skin tear noted" If that facility staff failed to be approaches for Resident I on 10/27/22. Subsequently, if another fall on 11/04/22. Interview conducted on Employee #2 (Director of ade aware of the findings of #68. He acknowledged in no further comments. R 3211.1				
require dialysis receiv	७ वयवत वटा शाव्यव, व्यागिवावाया।				
	ROVIDER OR SUPPLIER RD BAPTIST NURSING F SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page 10/28/22 had the approaches of Encourage resident to light within reach." 11/02/22 at 3:21 PM (evaluation) & (and) to walking" 11/04/22 at 4:32 PM [Fall)] "Total Fall Ris Necessary Indicate Continue current plant 11/04/22 at 5:41 PM [pm, resident was note (television) areaOn verbally responsive, or bleeding, swelling or state of the resident sustained. The evidence showed identify and implement #68 after he had a fall the resident sustained. During a face-to-face 11/07/22 at 1:10 PM, Nursing/DON) was mader for Residents' #80 and the findings and made Cross reference DCM Dialysis CFR(s): 483.25(l) Dialysis. The facility must ensured.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 78 10/28/22 had the approaches of, "PT/OT consult PRN. Encourage resident to ask for assistance and call light within reach." 11/02/22 at 3:21 PM [physician's order] "PT eval (evaluation) & (and) treatto address difficulty in walking" 11/04/22 at 4:32 PM [Fall Risk Assessment (Post Fall)] "Total Fall Risk Score: 17No Referrals Necessary Indicate care plan action taken. Continue current plan of care." 11/04/22 at 5:41 PM [Nursing Note] "At 3:20 pm, resident was noted with a fall at the TV (television) areaOn assessment: alert and verbally responsive, oriented x 1(self), no bruises, bleeding, swelling or skin tear noted" The evidence showed that facility staff failed to identify and implement approaches for Resident #68 after he had a fall on 10/27/22. Subsequently, the resident sustained another fall on 11/04/22. During a face-to-face interview conducted on 11/07/22 at 1:10 PM, Employee #2 (Director of Nursing/DON) was made aware of the findings for Residents' #80 and #68. He acknowledged the findings and made no further comments. Cross reference DCMR 3211.1 Dialysis CFR(s): 483.25(l)	ROVIDER OR SUPPLIER RD BAPTIST NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 78 10/28/22 had the approaches of, "PT/OT consult PRN. Encourage resident to ask for assistance and call light within reach." 11/02/22 at 3:21 PM [physician's order] "PT eval (evaluation) & (and) treatto address difficulty in walking" 11/04/22 at 4:32 PM [Fall Risk Assessment (Post Fall)] "Total Fall Risk Score: 17No Referrals Necessary Indicate care plan action taken. Continue current plan of care." 11/04/22 at 5:41 PM [Nursing Note] "At 3:20 pm, resident was noted with a fall at the TV (television) areaOn assessment: alert and verbally responsive, oriented x 1(self), no bruises, bleeding, swelling or skin tear noted" The evidence showed that facility staff failed to identify and implement approaches for Resident #68 after he had a fall on 10/27/22. 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Encourage resident to ask for assistance and call light within reach." 11/02/22 at 3:21 PM [physician's order] "PT eval (evaluation) & (and) treatto address difficulty in walking" 11/04/22 at 5:41 PM [Nursing Note] "At 3:20 pm, resident was noted with a fall at the TV (television) areaOn assessment alert and verbally responsive, oriented x 1(self), no bruises, bleeding, swelling or skin tear noted" The evidence showed that facility staff failed to identify and implement approaches for Resident 488 after he had a fall on 10/27/22. Subsequently, the resident sustained another fall on 11/04/22. During a face-to-face interview conducted on 11/07/22 x 11:10 PM, Employee #2 (Director of Nursing/DON) was made aware of the findings for Residents #80 and #68. He acknowledged the findings and made no further comments. Cross reference DCMR 3211.1 Dialysis Cross reference DCMR 3211.1 Dialysis The facility must ensure that residents who	ROYLDER OR SUPPLIER RD BAPTIST NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPORTERY MUST BE PRECEDED BY PILL REGULATORY OR LSC DENTIFYMS INFORMATION) COntinued From page 78 10/28/22 A BUILDING COntinued From page 78 11/02/22 at 3:21 PM [physician's order] "PT eval (evaluation) & (and) treatto address difficulty in walking" 11/04/22 at 4:32 PM [Fall Risk Assessment (Post Fall)"Total Fall Risk Score: 17No Referrals Necessary Indicate care plan action taken. Continue current plan of care." 11/04/22 at 5:41 PM [Nursing Note] "At 3:20 pm, resident was noted with a fall at the TV (television) area On assessment: alert and verbally responsive, oriented x 1(self), no bruises, bleeding, swelling or skin tear noted" The evidence showed that facility staff failed to identify and implement approaches for Resident #88 after he had a fall on 10/27/22. Subsequently, the resident sustained another fall on 11/04/22. During a face-to-face interview conducted on 11/07/22 at 1:10 PM, Employee #2 (Director of Nursing/DON) was made aware of the findings for Residents' #80 and #68. He acknowledged the findings and made no further comments. Cross reference DCMR 3211.1 Dialysis The facility must ensure that residents who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING				(X3) DATE SURVEY COMPLETED			
		095020	B. WING_			1	C /09/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10912022
0700045		OMP		1818 N	NEWTON ST. NW		
STODDAR	RD BAPTIST NURSING H	OME		WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 698	the residents' goals a This REQUIREMENT by: Based on observation interview, for one (1) facility staff failed to: interventions for care dialysis access site; a (pressure bandage) a #79. The findings included Review of the policy " Receiving Dialysis" la directed, "residents will receive nursing or individualized needs: shunt, fistula, or graft) residents access will I subsequent nursing in dialysis resident will b plan" During an observation 11/07/22 at 9:22 AM, chest permacath and	idards of practice, the in-centered care plan, and ind preferences. It is not met as evidenced in, record review and staff of 41 sampled residents, develop and implement and monitoring of his ind have an emergency kit in the bedside of Resident in the bedside of Resident in the care in the existence type (i.e., and location of the pe noted and referenced in otes care provided to the edocumented in the care	F	98	F 698 – Dialysis - Resident #79 1. Resident was assessed by the DON on 11/4/22. The care pla was updated to include new dialysis access site. A dialysis emergency kit was also place the bedside on 11/4/22. There were no negative outcomes for this resident. 2. Care plan for one other reside was reviewed and updated to address availability of dialysis emergency kit on 11/4/2022. There are no negative outcomfor this resident. There are no other residents on dialysis. 3. The policy on care of resident with dialysis was revised on 11/10/2022 to address the new for a dialysis emergency kit at bedside. The nurse educator provided an in-service to all nursing staff on where to obta BP measurements on resident with dialysis access sites and need for an emergency dialysis at the dialysis resident's bedside in service was done on 11/10/4. The nursing manager will inspall dialysis residents' bedside dialysis emergency kit and will conduct blood pressure	in ts the is kit ide. 22. ect for	
	resident's bedside with Practical Nurse/ LPN) observation, the employeer is the site for Reaccess site. Employees show the surveyor whemergency dialysis kit located. The employee	n Employee #18 (Licensed at the time of the byee stated that the left sident #79's new dialysis #18 was then asked to			observation at one random day/week to ensure staff are obtaining blood pressure measurements on the correct arm. Bedside rounds and BP observation will continue week until there is sustained 100% compliance for 3 months.	cly	·

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	IPLE CONSTRUCTI IG	(X3) DATE SURVEY COMPLETED		
							С
		095020	B. WING _			11	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		STREET ADDRE 1818 NEWTON WASHINGTO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	dialysis kit. When ask #79 have an emerger bedside, Employee # will have to refer you Manager." Resident #79 was rea 09/22/22 with diagnos Kidney Failure, Pleura Obstructive Pulmonar Review of Resident # revealed the following 09/22/22 at 10:05 PM lumen line was noted 09/22/22 [physician's dialysis every Monday A Significant Change showed facility staff or impairment and receiv Care plan focus area " (End Stage Renal Disc Dependent" showed, " 09/30/2022. Approach to dialysis access site, (weight gain, increased urinary outp stools, confusion, seize will be seized to the seize of the	red why Resident doesn't acy dialysis kit as his 18 stated, "I don't know. I to my Assistant Nurse admitted to the facility on ses that included: Acute al Effusion and Chronic by Disease (COPD). 79's medical record [Nursing Note] "Double on resident's right chest" order] "Resident is for a wednesday, Friday" MDS dated 09/27/22 and dis Hemodialysis while a resident. [Resident #79] has ESRD ease) and is Hemodialysis chast reviewed/revised and is Hemodialysis and trauma and monitor for fluid excess and BP (blood pressure); gular vein distention, SOB moist cough, rales, rhonchi, resening of edema, aut, nausea/vomiting; liquid ures). Hemodialysis at"	F	Dialysis -	- Resident #79 continued Completion date January 9, 2023 Director of Nursing		
	_	Nursing Note] "Left for . AV (arteriovenous) graft					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		, ,	E SURVEY PLETED
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		095020	B. WING			11	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	ОМЕ		STREET ADDRESS 1818 NEWTON ST WASHINGTON,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B -REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	10/27/22 at 11:34 PM wheeled back on to the surgical site [new AV transparent pressure obleeding noted" 10/29/22 at 12:11 AM Note] " dialysis acceed (AVG) dressing is intableeding noted. [Left] bruits and thrills upon" There was no docume staff revised Resident include his new dialysing graft] and the associate failed to have an emerbed side. During a face-to-face in 11/07/22 at 9:33 AM, is Assistant Unit Manage findings and stated, "Lestart or revise the care the residents in the face emergency [dialysis] kills.	[Nursing Note] "Resident to unit at 7:10 pmLeft arm graft site] observed with dressing. No signs of [Nursing Post Dialysis ass site; [left] arm AV graft ct and dry, no active arm AVG is positive to auscultation and palpation ented evidence that facility #79's dialysis care plan to is access site [left arm AV ed care of the site; and regency dialysis kit at his Interview conducted on Employee #15 (1st Floor arm) acknowledged the PNs are not allowed to plans" and that "none of cility (2 in total) have its at their bedside."	F	598			
	Nursing/DON) stated, 'cart on each unit where pressure dressings and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF		(X3) DATE SURVEY COMPLETED		
							;
		095020	B. WING			11/0	09/2022
NAME OF PI	ROVIDER OR SUPPLIER	20-7-10-7-10-7-10-7-10-7-10-7-10-7-10-7-		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
CTODDAG	D DARTICT MURCINIC II	0145		1818 NEV	VTON ST. NW		
STODDAR	RD BAPTIST NURSING H	OME		WASHIN	IGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
				F 711	- Resident #79		
F 711	Continued From page	82	F 71	1			
F 711	Physician Visits - Rev	iew Care/Notes/Order	F 71	1 1.	Physician inadvertently wrot		
SS=D	CFR(s): 483.30(b)(1)-	(3)			note on the wrong resident.		
					physician assessed resident		
	§483.30(b) Physician	Visits			note was invalidated by the (MD) on 12/16/22. The thera		
	The physician must-				recreations aide's quarterly i		
	0.400.00(1.)(4) D	0			was written for the prior 3 m		
		the resident's total program			but was written while the res		
	each visit required by	lications and treatments, at			was out of the facility. The T	I	
	section;	paragraph (c) of this			note was invalidated by the		
	0000011,				on 12/16/22. There were no		
	§483.30(b)(2) Write, s	ign, and date progress			negative outcomes for this re		
	notes at each visit; an				as a result of this deficient p	I .	
				2.	A review of all residents tran	- 1	
		d date all orders with the			to the hospital was conducte		
	exception of influenza				12/22/22 by the Health Infor		
	vaccines, which may be				Manager to identify any simi	ıar	
	physician-approved fa				error. There were no other residents affected by this de	ficient	
	assessment for contra				practice.	licient	
		is not met as evidenced		3	The Administrator provided		
	by:	ew and staff interview for		0.	physician re-education on ac	curacy	
		residents, the physician			of documentation. The Direct		
		valuate resident's condition			Therapeutic Recreations pro		
ľ	•	are as evidenced by: no			the TR staff in service on		
1		n indwelling catheter for			documentation of quarterly n		
	one resident and a phy	ysician progress note that			for residents away from the f	acility	
	inaccurately document	ted the physician's			on 12/14/22.		
I		essment and care of one		4.	Physician entries and therap		l
	resident. Residents' #2	298 and #79.			recreations notes on residen		
					are away from the facility will		
	mmile a production of the first				monitored by the Health Info		
	The findings included:				Manager weekly and reporte	u to	
f	Daviou of the nelice !!!	Joseph Roserd			QAPI monthly. Completion date: Jan. 9, 202	,,	
	Review of the policy "I	realth Record vised on 02/10/20 showed,			Health Information Manager		
	" Each resident who			0.	ricalui imormation Managei		
- 1		ther staff at [Facility Name]]					
F .		inical care must have a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED		
		095020	B. WING		1	C 1/09/2022	
	ROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 711	record kept at all time should be documented provided or as soon a completed" Review of the policy "I reviewed on 07/22/22 written by a licensed of Clinical notes are rangurse quarterly. Finding QI (Quality Improvem meeting Clinical not wound include: descrid drainage, presence of condition of skin around"	Documentation Criteria" last directed, "Clinical notes are nurse in the medical record. domly audited by registered ng of audit are reported to ent) team with scheduled es for decubitus/open ption of the area, size, finecrotic tissue, and the area treatment skin: note condition of reas exist note for	F 71	1			
	care as evidenced by indwelling catheter that to the facility. During a facility tour capproximately 3:15 Phobserved in her room bag uncovered, visible Resident #298 was ad 10/28/22 with multiple	ition and total program of no physician's order for an at was present on admission onducted on 10/31/22 at M, Resident #298 was with her urine collection from hallway. Imitted to the facility on diagnoses that included: ind Change in Bowel Habit.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		095020	B. WING_				C /09/2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010				10312022
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
	10/28/22 [Nursing Pro#298]newly admittedCatheter was placed Resident however fait was replaced and is the with urology" 10/29/22 [History and indwelling Foley inset urinary retention" Care plan focus aread initiated on 10/31/22 he have catheter care mevidenced by not exhourethral trauma" From the date of admitication of a physicial with a progress indwelling uring the progress indwelling uring a face-to-face 11/08/22 at 3:35 PM, Nursing/DON) stated, catheter, she [Resident evening." Cross reference DCM 2. Facility failed to ensprogress note, that do involvement in the ass Resident #79 was admitted.	ogress Note] " [Resident and from [Hospital name] and with improvement. Iled void trial and catheter to be on until next follow up on the property of the provided in the hospital due to the property of the provided in the hospital due to the goal of, "Resident will anaged appropriately as ibiting signs of infection or the provided in the provide	F 7				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
							С
		095020	B. WING			11/	/09/2022
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAR	RD BAPTIST NURSING H	OME			1818 NEWTON ST. NW		
310000	AD DAI 1101 NONOING 11	OIIIL		١	WASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG	THEODERICATION OF THE	is is a second of the second o	TAG		DEFICIENCY)		
F 711	Continued From page	85	F	711	1		
	Systolic (congestive)	and Diastolic(congestive)					
	Heart Failure.	, ,					
	Review of Resident #3	79's medical record showed					
	the following:	o o medical record showed					
	07/00/00 -4 40-57 DM	INcoming Natal IID asidest					
		[Nursing Note] "Resident rgency room) via 911. MD					
	(medical doctor) made						
	(111041041 400101) 111441						
	07/24/22 at 2:51 AM [Nursing Note] "Call placed					
		ref (reference) to resident					
		by charge that resident					
	was admitted. No furth	ner information given"					
	08/16/22 at 12:31 PM	[Physician's Note]					
		Note. Date: 8/16/2022			ŕ		
	resident of this facility		'				
	Clinically he has cor	ntinued to do well and has				ļ	
	remained stableThe						
	issues regarding his c					ļ	
		Clear to auscultation and					
		cularS1 and S2 (heart limits There has been					
		g his care. We will continue					
ľ	-	ent. Plan: Remains clinically					
- 1		nt management. [Name of					
	Physician], MD Attend						
	09/22/22 at 10:04 DM	[Nursing Note] "[Resident					
		n [Hospital Name] at 1:35					
	pm"	ii įi iospitai Namej at 1.00					
	h						
	The evidence showed	that the physician					
	documented to doing a	an assessment on Resident					
	#79 even though he w	as hospitalized from					
	07/23/22 to 09/22/22.						
	During a face-to-face in	nterview conducted on					
<u></u>							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		095020	B. WING			l .	C
	201/255 OD 01/257 155	033020		TOPOT 100	DESCRIPTION OF THE CORP.	11/	09/2022
NAME OF P	ROVIDER OR SUPPLIER		l l		RESS, CITY, STATE, ZIP CODE		
STODDAR	RD BAPTIST NURSING H	OME	1	818 NEWTO	ON ST. NW		
			l v	VASHINGT	FON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	ID .		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BI ROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
17.0			17.0		DEFICIENCY)		
AND SAN ASSESSMENT OF THE SAN ASSESSMENT OF				F726 -	- Resident #99		
F 711	Continued From page	e 86	F 711		The Director of Nursing		
	11/07/22 at 9:50 AM, Employee #2 (Director of				provided Employee#13 ver	bal	
		wledged the findings and			re-education on medication		
	made no further comr	nents.			administration principles (5		
					rights), residents rights, an		
	Cross reference DCM	IR 3207.10			infection control procedure		
F 726	Competent Nursing S	taff	F 726		on 11/9/22. There were no		
SS=D	CFR(s): 483.35(a)(3)((4)(c)			negative outcomes as a re-	sult	
					of this deficient practice.		
	§483.35 Nursing Serv	ices		2.	The nurse educator conduc	cted	
	The facility must have	sufficient nursing staff with			random med pass		
	the appropriate competencies and skills sets to				observations for complianc		
	provide nursing and re	elated services to assure			with medication administra	tion	
		tain or maintain the highest			principles, residents rights	and	
		nental, and psychosocial			infection control		
	-	ident, as determined by			(handwashing/hand hygien		
		and individual plans of care			10 staff members who pass	8	
	and considering the n				meds were observed and		
		ty's resident population in			demonstrated compliance.		
		acility assessment required		3.	•		
	at §483.70(e).				all licensed nursing staff ar	in-	
	0.400.05(.)(0).Tl. (***			service on medication		
	§483.35(a)(3) The fac				administration, resident rigi		
		the specific competencies			and infection control princip		
		ry to care for residents'			(hand washing/hand hygier	ne)	
	needs, as identified th	•			on 11/14/22 (on-going).		
	assessments, and des	scribed in the plan of care.		4.	Adherence to medication	,	
	8483 35(a)/4) Drovidin	ng care includes but is not			administration principles, he	ana	
		valuating, planning and			hygiene will be monitored	-4	
		care plans and responding			monthly by the nurse educa	ator	
	to resident's needs.	care plans and responding			through weekly random		
	to resident a needs.				observations. Staff found	,,	
	§483.35(c) Proficiency	of nurse aides			violating these principles w		
		re that nurse aides are able			be provided re-education a progressive discipline. Find		
	to demonstrate compe				will be reported to QAPI	"'Y	
	techniques necessary				monthly.		
	needs, as identified the			5	Completion date: 1-9-2023		
		cribed in the plan of care.		5. 6.	•		
				O.	Nuise Educator		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
!		095020	B. WING_				C /09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP CO 1818 NEWTON ST. NW WASHINGTON, DC 20010	ODE		, 00, 100 11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BI IE APPROPRI	_	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on observation interview, for one (1) facility staff failed to end the specific compressary to care for assure resident safety medications. Resident The findings included Review of the policy to Medications Administro foctober 2018, instrappropriateRead the pouring the medication medication with finger before administering a arm band or photogra or check with other state Explain to the resident be administered. The informed of all medicaAdminister medication will be destroyed by washing down drain and destruction according. During an observation 8:42 AM, Employee #*Nurse) was observed in that was located in the contained unwrapped to Resident #99. Emplithe surveyor before shifted for the su	is not met as evidenced n, record review, and staff of 41 sampled residents, insure that licensed nurses betencies and skill sets a resident's needs and y when administering t #99. itled "General Guidelinesfor ration" with a revision date ucted, "Cleanse hands as e label three times before nNever touch any of the sIdentify the resident any medication. Check the ph, call resident by name, aff members if necessary the type of medication to resident has the right to be tions that are administered on and remain with resident vallowedOnce removed ontainer, unused doses y flushing in toilet or and documenting the to policy" on 11/09/22 starting at 13 (Licensed Practical etrieving a white paper cup medication cart and loose tablets to administer oyee #13 was stopped by	F 7	'26			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		095020	B. WING		1	C /09/2022		
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	70072022		
STODDAF	RD BAPTIST NURSING H	ОМЕ		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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 726	Continued From page was keeping the pills	e 88 in the medication cart to	F 72	6				
	observed not perform directly touched the tabe given to the reside entered Resident #99 herself, verifying the raddressing the reside did not inform Resided she was being adminished in the "flat pills". Employer assess the resident swallowing difficulties. In a face-to-face interest of observation, Employers ince I entered the reneeded to say anythin Resident #99 was admitted.	ant by name. Employee #13 Int #99 of what medications istered. Resident #99 stated big pills" and can only take ee #13 did not acknowledge t's concern with possible view conducted at the time eyee #13 further stated, bom earlier, I did not know I eg else." mitted to the facility on e diagnoses that included: sion, and						
	A review of the medica following:	al record revealed the						
	10/21/22 [physician's (Order] "Diet: Pureed"						
	facility staff coded: the Interview for Mental St "15" which indicated in of care behavior exhib							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRI	(X3) DATE SURVEY COMPLETED	
			71. 5012511			С
		095020	B. WING _			11/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		1818 NEWT	DRESS, CITY, STATE, ZIP CODE ON ST. NW TON, DC 20010	Manual Control
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI PROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
SS=D	have the appropriate sets to provide nursin assure Resident #99's During a face-to-face 11/08/22 at 9:23 AM, Nursing) stated, "She orientation and her prochallenges with staffir manager for this unit." Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(§483.45 Pharmacy Srvcs/Procidrugs and biologicals them under an agreen §483.70(g). The facility personnel to administe permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accuradispensing, and admir biologicals) to meet the §483.45(b) Service Comust employ or obtain pharmacist who-	that Employee #13 did not competencies and skills g and related services to a safety. interview conducted on Employee #2 (Director of (Employee #13) is on eceptor called out. We have a edures/Pharmacist/Records 1)-(3) ervices de routine and emergency to its residents, or obtainment described in y may permit unlicensed er drugs if State law references (including procedures te acquiring, receiving, histering of all drugs and eneeds of each resident. ensultation. The facility the services of a licensed	F 75	2. 55	Resident # 24's controlled medications were reviewed reconciled on 11/8/22. Discontinued narcotics were disposed of on 11/09/22. The were no negative outcomes Resident #24 as a result of the deficient practice. Controlled medications for a residents were reviewed and reconciled on 11/9/22. Medication discontinuation orders for all residents were reviewed 11/9/22 and 100% all other discontinued medications were returned. There were no negative outcomes to other residents as a result of this deficient practice. The Nurse Educator provide all licensed nursing staff an is service on disposal of discontinued narcotics and medications, proper reconciliation process of controlled medications and documentation on 11/14/22. Reconciliation and disposal of discontinued narcotics and medication will be audited weekly by the director of nursing or designee for 3 months of sustained 100% compliance. Findings will be reported to QAPI monthly. No compliant staff will be reeducated and placed on progressive discipline. Completion date: Jan. 9, 202	ere to this ill d of
		n of pharmacy services in				:3

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
	:	095020	B. WING			C	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			11/09/2022	
(X4) ID PREFIX TAG			ID PREFI) TAG		ION SHOULD BE HE APPROPRIA		
F 755	Continued From page	90	F7	755			
	receipt and disposition sufficient detail to ena reconciliation; and						
	order and that an accis maintained and per This REQUIREMENT by:	is not met as evidenced					
	interview, for one (1) of facility staff failed to:	n, record review, and staff of 41 sampled residents, properly waste a and reconcile narcotics.					
	The findings included:						
	of Schedule II Medica October 2018, instruct count or measure the	policy titled "Administration tions" with a revision date of ed "The nurse will then remaining drug quantity in nount remaining onto the eet.					
	Substances" with a rev 2018, instructed "For medications, it is the re destroy all discontinue	tled "Disposal of Controlled vision date of October rall residents' schedule II-V esponsibility of the facility to d controlled drugs at the ne same documentation"					
	Facility staff failed to #24's controlled medic discontinued by the pre-						
		on 11/08/22 at 9:20 AM, on edication cart A, two blister					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		095020	B. WING		C 11/09/2022		
	ROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	11/00/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	N (X5) DBE COMPLETION RIATE DATE			
	packs of Clonazepam observed for Resident of Clonazepam 1 mg pills. According to the had been wasted on (Licensed Practical N Resident #24's Clona discontinued over a waccidentally took a pill package and then had Resident #24 was adr 03/29/22, with multiple Bipolar Disorder, Anxi Review of the medica following: 10/29/22 [physician's (Discontinue)Clonazeday" The evidence showed discontinued by the pit to properly to destroy for 1 mg tablets. DCMR 3227.13 2. Facility staff failed to multiple days. During an observation 9:20 AM on the first-flof form titled "Narcotic Si on the following dates: 10/30/22, and 11/07/22	(antianxiety) were t #24, one pack blister pack (milligram), containing 49 reconciliation sheet, one pill 11/07/22. Employee #14 urse) explained that zepam 1 mg was reek ago and that someone I from the discontinued I to waste it. mitted to the facility on re diagnoses that included: rety, and Chronic Hepatitis. I record revealed the order] "DC repam 1 MGTwice a that for 10 days after it was rysician, facility staff failed Resident #24's Clonazepam or reconcile the narcotics on conducted on 11/08/22 at ror medication cart A, the regn-In Sheet" revealed that 10/02/22, 10/28/22, 2, only one nurse signed in reperforming the shift count	F 75	5			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С	
		095020	B. WING		11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAR	RD BAPTIST NURSING H	OME	'	1818 NEWTON ST. NW		
STODDAI	ND BAF 1131 NORSING H	OME	١ ،	WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 755	Continued From page	92	F 755	F756 – Resident #60		
F 756 SS=D	perform the reconcilia above-mentioned date During a face-to-face observation, Employed Nurse) acknowledged further comment. Cross reference DCM Drug Regimen Review CFR(s): 483.45(c)(1)(§483.45(c) Drug Regi §483.45(c)(1) The drug Regimen Review CFR(s): 483.45(c)(1) The drug Regimen Review CFR(s): 483.45(c) Drug Regimen Review CFR(s	interview at the time of the ee #15 (Licensed Practical I the finding and made no IR 3224.3 (d) w, Report Irregular, Act On 2)(4)(5)	F 756	 Medication Regimen Review for resident #60 was referred to the psychiatrist on 10/13/22. Consultation with the psychiatrist was completed on 11/11/22. MRR's of residents with referral to the psychiatrist were reviewed on11/11/22 for timely referral to the psychiatrist. There were no MRRs with outstanding referrals to the psychiatrist. Inservice for all licensed nursing staff regarding 		
	§483.45(c)(4) The phairregularities to the attractility's medical direct and these reports must (i) Irregularities included rug that meets the cr (d) of this section for a (ii) Any irregularities induring this review must separate, written report attending physician and director and director or minimum, the resident and the irregularity the	ermacist must report any ending physician and the tor and director of nursing, st be acted upon. Ite, but are not limited to, any iteria set forth in paragraph an unnecessary drug. Ite be documented on a ret that is sent to the aid the facility's medical of nursing and lists, at a st's name, the relevantdrug, a pharmacist identified.		timely notification of physicians on MRR consults was provided by the Nurse Educator on 11/14/2022. 4. The DON or designee will audit all MRRs for physician notification and response to pharmacists' recommendations monthly and reported to QAPI quarterly. 5. Completion date: Jan 9 2023 6. Director of QAPI		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
			A. BOILDIN	<u> </u>		•		С
		095020	B. WING_				Ī	/09/2022
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET	ADD	RESS, CITY, STATE, ZIP CODE	<u> </u>	
STODDA	RD BAPTIST NURSING H	OME	ĺ	1818 NE	WTC	ON ST. NW		
STODDAI	ND BAFTIST NORSING H	ONE.		WASHII	NGT	ON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE ADEFICIENCY)		OSS-REFERENCED TO THE APPROPRIA		DATE
F 756	irregularity has been action has been taken be no change in the no physician should doct	reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in	F 7	B-1 56	1.	The DON and nursing staff were provided information on where to locate MRRs. MRR for Resident # 60 was found and provided to		
	maintain policies and	ility must develop and procedures for the monthly			2.	psychiatrist on11/11/22. Psychiatrist reviewed the MRR on 11/11/22. All residents' charts were		
	limited to, time frames the process and steps when he or she identi requires urgent action This REQUIREMENT by:	that include, but are not a for the different steps in the pharmacist must take fies an irregularity that to protect the resident. It is not met as evidenced				audited for proper placement of MMR in the residents' medical record of 11/11/22. There were no negative outcome to other residents as a result of this deficient practice.		
	one (1) of 41 residents the action of notifying in response to a mont regimen review) and t	o have an established,			3.	All licensed nursing staff were provided an in-service on MRR policy and where locate MRRs on11/14/22 b Nurse Educator.	:0	
	consistent location for communication with the Resident #60.	the MRR forms to facilitate ne State Surveyors.			4.	The consultant pharmacist will audit MRRs for MD response monthly and report to QAPI quarterly.	ort	
	The findings included:				5.	Completion date: January 9 2023	9,	
1	to the monthly MRR (r	o take the action of ist as ordered, in response nedication regimen review) uction for Resident #60.			6.	Director of QAPI		
	Resident #60 was adn 10/08/21 with multiple Insomnia, Thyroid Disc Anemia, Orthopedic C Disorder,	diagnoses that included: order, Tobacco Use,						
	Review of Resident #6 revealed the following:							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CON: NG	(X3) DATE SURVEY COMPLETED			
			/ (50.25				С
		095020	B. WING			11	/09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		1818 N	T ADDRESS, CITY, STATE, ZIP CODE EWTON ST. NW IINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 756	(by mouth) qhs (every	order] "Trazadone g (milligram) tab (tablet) po night) for insomnia" [Pharmacist Note] "MRR	F	756			
	10/13/22 showed faci impaired cognitive res Antidepressants. Care plan focus area more medications" las 10/18/22 had the follo with pharmacy recoming the same communication of the same communication	"[Resident #60] is on 9 or treviewed/revised on wing approach, "Follow up mendations"					
	approaches, "Adminis Monitor effectiveness 10/20/22 at 6:58 AM [IPt's (patient's) nurse pharmacy recommence reviewed and address Recommendation: G Trazadone for Insomn consult for psych (psy reconciliation." 10/21/22 [physician's of for psych medication reconstruction of the control of	leep pattern" last 0/18/22 had the following ter Trazadone asordered. and side-effects" Physician's Assistant Note] " reported that pt has a lation that needs to be ed. Pharmacy radual reduction of ia Order Psychiatrist chiatric) medication					<i>j</i>
	10/21/22 12:51 PM [Ni consult for psych medi					ļ	<i>,</i>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		095020	B. WING				C /09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP C 1818 NEWTON ST. NW WASHINGTON, DC 20010	ODE		100 100 100 100 100 100 100 100 100 100
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
	ordered by PA (Physical Review of the Resided 11/08/22 showed that 10/21/22 (totaling 18 documented evidence by the psychiatrist wo consult in order after reduction of Trazador During a face-to-face 11/08/22 at 10:53 AM Practical Nurse/LPN) order for a psych consorder calls and lets the When asked if the psyaware of Resident #6 Employee #18 stated will find out." It should be noted that provide any document psychiatrist was notified consult had been common to suffer any harm from the facilitate communic Surveyors. 06/12/22 at 1:01 PM F completed. Recomme prescriber."	ent #60's medical record on the since the ordered date of days), there is note that the resident was seen in was there any evidence was notified of the resident's this treatment (gradual dose the). Interview conducted on the stated, "When there's an sult, the nurse receiving the epsych doctor know." When there's an sult, the stated point of the consult, the stated point of the end of the consult of the end of the consult of the consult of the consult of the end of the end of the consult of the end of	F	756			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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		095020	B. WING			11/09/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
STODDAF	RD BAPTIST NURSING H	OME		WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	
F 756			F7	756		
	Recommendation ma	de to prescriber."				
	11/08/22 at 3:48 PM,	interview conducted on Employee #2 (Director of that he was not able to t #60's MRR forms.				
F 761 SS=D	Cross Reference DCN Label/Store Drugs and CFR(s): 483.45(g)(h)(d Biologicals	F 70	61		
	Drugs and biologicals	and cautionary				
	§483.45(h) Storage of	Drugs and Biologicals				
	biologicals in locked co	ty must store all drugs and ompartments under proper and permit only authorized				
	locked, permanently a storage of controlled d the Comprehensive Dr Control Act of 1976 an	lity must provide separately ffixed compartments for rugs listed in Schedule II of rug Abuse Prevention and d other drugs subject to e facility uses single unit				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		095020	B. WING _		1	C /09/2022
STODDAR (X4) ID		OME ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010 PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	•	/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE
	quantity stored is min be readily detected. This REQUIREMENT by: Based on observation interview, in two (2) of failed to: store medical professional standard and initial Insulin vials. The findings included: A review of the facility Labels" revised in Oct decrease the potential properly labeling medispensed will be lastate, and Local laws label should be destrous the professions to the Ph. 2018, instructed, " Unot a controlled substate refrigeration may be remame] if they are in a recontainer" 1. Facility staff failed to #62's and #35's medical medication cart". During an observation the first-floor, Employed Nurse) stated that the	tion systems in which the imal and a missing dose can is not met as evidenced in, record review, and staff beservations, facility staff ations in accordance with sof practice; and to date in its policy titled "Medication ober 2018, instructed, " To led of medication errors edications, all medications abeled according to Federal, Containers having no belied according to Federal, Containers having no syed" I's policy titled "Returning armacy" revised in October nused medications that are ance nor require enturned to [Pharmacy manufacturer's sealed in properly discard Resident ations from the "isolation in an antion of the "isolation medication cart", VID-19 positive residents, ney didn't have any	F7	F761 — Residents # 62 and 35 discontinued medication discarded on 11/9/22. no negative outcomes residents. 2. All other medication can checked for any discon medications on 11/9/2 were no discontinued in any of the other cart. 3. Licensed Nursing staff provided in-service on for discarding discontinor discharged resident medications by the Nu on 11/14/22 (on-going). 4. The nursing supervisor medication carts week discontinued medication that were for residents who have discharged or expired. be provided to QAPI m. 5. Completion date: Jan. 9. 6. Nurse Educator	ons were There were to either arts were otinued 2. There medications s checked. were the process nued, expired s rse Educator of will check by for any ons or prescribed been Findings will conthly.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
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		095020	B. WING			11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAR	RD BAPTIST NURSING H	HOME		1	818 NEWTON ST. NW		
010000	CD DAI TIOT HOROITO	TOME		٧	WASHINGTON, DC 20010		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES ID			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG	NEGOE WORT OR	200 IDENTIFICATION	IAG		DEFICIENCY)		
F 761	Continued From page	e 98	F	761			
		of the medication cart, the					
	following medication						
	observed:	and passes to the					
	For Resident #62, wh	no was admitted to the			·		
	second floor, room 22	21 bed B on 09/07/22:					
		d hormone supplement) 88					
	Mg (milligrams)	ood pressure) ER (extended					
	release) 600 mg	od pressure) ER (extended					
		erol lowering drug) 40 mg					
	Acetaminophen (Ana						
	, , , , , , , , , , , , , , , , , , , ,	3,3					
	For Resident #35, wh	o was transferred to the					
	second floor in Augus	st 2022:					
	A t :						
	Acetaminophen 500n Senna (laxative) 8.6-5						
	Clopidogrel (anticlotti						
	Aspirin (analgesic) Ch						
	Vitamin B 12 1000mg						
	Amlodipine (lowers bl						
		enhancing medication) 10					
	mg						
	Lisinopril (lowers bloo	, ,					
	Acetaminophen 325 n	<u> </u>					
	Omeprazole (for gastı Gabapentin (anti-seiz						
	Gabaperiuri (anti-seiz	ure) 400 mg					
	During a face-to-face	interview conducted at the					
	time of the observatio						
	acknowledged the find						
	-						
	Cross reference DCM	R 3227.13					
	O E						
		o date and initial 2 vials of					
	Insulin that were open	iea.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUC			SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER					RESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	OME			818 NEWTO VASHINGT	N S1. NW ON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BI DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773 SS=D	first floor, 2 vials of Inthat did not have the date, or staff initials with the date, or staff initials with the date, or staff initials with the date, or staff initials with the date, or staff initials with the date, or staff initials with the date, or staff initials with the date of the dat	In on 11/08/22 at M, medication cart A, on the sulin were observed opened date opened, expiration ritten on the vials. Inducted at the time of the e #15 acknowledged the further comment. R 3227.19 Order/Notify of Results ii)(ii) Iility must-boratory services only when a physician assistant; nurse nurse specialist in a law, including scope of ordering physician, curse practitioner, or clinical pratory results that fall tence ranges in accordance d procedures for ioner or per the ordering is not met as evidenced Ew and staff interview, for residents, facility staff y the ordering physician of		7773		Unlabeled and opened insulin or multidose vials on medication cart A were immediately discarded on 11/8/22. All other medication storage were searched for unlabeled open vials. There were no other insulin vials found. All licensed nurses were provided an in-service on proper storage and handling of insulin and other multidose vials in the facility the Nurse Educator on 11/14/22 (ongoing). The Nursing Supervisor will check all medication storage weekly for proper labelling of insulin and other multi dose vials. Findings will be reported to QAPI monthly. Monthly monitoring will continue un goal of 100% compliance is sustained for 3 months. Completion Date: January 9, 2023 Nurse Educator	1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1818 NEWTON ST. NW WASHINGTON, DC 20010		110012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	Review of the policy of Residents and Sta " Culture reports- a notified when culture obtained" Review of the policy on 03/15/22 docume be reported to the platimely mannerthe responsible for ensure drawn and resident #248 was a 10/19/22 with multiple Sepsis, Urinary Trace Prostatic Hyperplasis Review of Resident arevealed the following 10/19/22 at 9:56 PM admitted prior to the admitted at [Hospital had supra pubic cate to have urosepsis Is supra pubic catheter output of bloody color An Admission Minima 10/23/22 showed fact impaired cognition are catheter. 10/28/22 at 3:14 PM " Supra-pubic catheter."	titled "Microbiology Culturing aff" dated 09/14/11 directed, attending physicians is a and sensitivity results are titled, "Lab Results" revised ented, "All lab results should hysician and recorded in a night charge nurse is uring that all requested labsults returned" admitted to the facility on le diagnoses that included: at Infection (UTI) and Benign a (BPH). #248's medical record ag: [Nursing Note] " newly als admission resident was I Name] after a fall on 9/23/22 atheter insertedwas found Resident has a 16Fr (French) are further on admission" um Data Set (MDS) dated chility staff coded: moderately and had an indwelling	F7	F773 – Resident 248 1. Physician was notified the clinical reference 11/3/22 and new me obtained. Resident wand there was no ne outcome. 2. All urinalysis and cult sensitivity reports we out of clinical referent There were no other that were out of clinical reports to attendid by the nurse educated. 3. All licensed nurses wan in service on time lab reports to attendid by the nurse educated. 4. The DON or designed urinalysis and cultures sensitivity lab reports review medical record documentation of phynotification. Findings reported to QAPI corquarterly. 5. Completion date: Jar 6. Director of Nursing	e range on edication order was assessed egative elture and ere reviewed for neer range. Italian range evere provided ely referral of ing physicians for on 11/11/22. The will review also weekly and reds for ysician exit will be emmittee	or

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
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		095020	B. WING			11.	/09/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAF	RD BAPTIST NURSING H	OME		ļ	1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page 10/29/22 [physician's test: Urine Culture an time" 10/29/22 at 7:07 AM [collected for UA/C&S sensitivity)." 10/31/22 at 9:07 PM [UA/C&S result" 11/02/22 [American H "Urinalysisbloodnegative;protein 2+ negative RBC (red to many to count) referent blood cells) - TNTC reculture organism 1 CFU/ML (colony-formi	e 101 order] "Urinalysis; Other d sensitivity once - one Nursing Note] "Specimen (urinalysis/urine culture and Nursing Note] "awaiting ealth Associates] 3+ reference range reference range reference range olood cells) - TNCT (too once range- 0-2; WBC (white ofference range- 0-2 Urine (more than) 100,000 ong units per milliliter) onsa (bacteria). Organism 2 otterococcus faecalis	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	24-hour report book from showed no documents notified the ordering purinalysis and culture at the control of th	nterview conducted on Employee #15 (1st Floor er) stated, "Critical labs are e sent to our system where ound. Regardless, the o check that results are reviewed. I will make the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL		(X3) DATE SURVEY COMPLETED		
			A. BUILDING				
		095020	B. WING			ł	C / 09/2022
NAME OF P	ROVIDER OR SUPPLIER		"'	STREET ADD	DRESS, CITY, STATE, ZIP CODE	1	
				1818 NEWT	ON ST. NW		
STODDAR	RD BAPTIST NURSING H	OME	1	WASHING	TON, DC 20010		
(X4) ID	t .	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	C	(EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 776	Continued From page	102	F 776		6 – Resident #26		
	Radiology/Other Diag CFR(s): 483.50(b)(1)(F 776	1.	Venous Duplex was done on 9/24/22 which showed		
					no evidence of venous		
	§483.50(b) Radiology	and other diagnostic			clots. Arterial duplex was		
i	services.	ility must provide or obtain			ordered on 10/1/22 and		
		agnostic services to meet			done on 10/1 and result on 10/2/22 showed		·
	the needs of its reside				moderate stenosis of the	İ	
	responsible for the qu	ality and timeliness of the			right lower extremity.		
	services.				Resident was diagnosed	:	
	(i) If the facility provide				with "gangrene of the		
		must meet the applicable			right foot." Resident #26		
	in §482.26 of this sub	tion for hospitals contained			is no longer in the facility.		
	(ii) If the facility does r	•			No corrective action can be done for this resident		
	· ·	must have an agreement to			during this time frame.		
		from a provider or supplier		2.	All other charts were		
		ovide these services under			reviewed for doppler		
	Medicare.	:			studies on 11/11/22.		
	by:	is not met as evidenced			There were no other		
	•	ew and staff interview, for		^	doppler study ordered.		
	one (1) of 41 sampled			3.	•		
		dent with the necessary			provided all licensed nurses an in-service on		
		a timely manner, resulting			following up on orders		
	in the worsening of a r				pending completion on		
		at extended from the right			11/11/22.		
	big toe to midfoot. Res	ident #26.		4.	3		
	The findings included:				check doctor's orders for		
	The infullys included.				radiology weekly for		
	Resident #26 was adm	nitted to the facility on			completion and report to	l	
	05/10/19 with diagnose	es that included: Idiopathic		5	QAPI monthly. Completion date Jan.9,		
1	Peripheral Autonomic			J .	2023		
	Diabetes Mellitus and	Muscle Weakness.		6.			
	Pavious of Pasidont 40	6s medical record revealed			•		
i i	the following:	os medicai record revealed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TPLE CONSTRUCTION NG		(X3) DATE	E SURVEY PLETED
		095020	B. WING_				C /09/2022
	ROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, Z 1818 NEWTON ST. NW WASHINGTON, DC 20010	IP CODE	1 11	03/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD B O THE APPROPRI		(X5) COMPLETION DATE
F 776	An Annual Minimum I 05/10/22 showed faci cognitive impairment; refusal of care; no fur of motion; at risk for punhealed pressure ulconditions. 07/14/22 at 11:48 AM "Pt's (patient's) nurs complained of big toe toe] Order Colchicir 0.6mg (milligrams) tal tablet 1 hour later for 07/31/22 [Monthly Surecently completed ar cellulitis" 08/01/22 at 10:06 PM remains swollen, deni 08/06/22 at 7:34 PM [done regarding PVD (Data Set (MDS) dated lity staff coded: severe no behavior issues or nctional limitations in range pressure ulcers; and no cers or any other skin [Physician's Assistant Note] se reported that pt pain and redness [right ne (decreases swelling) polet, give 2 tablet x 1, then 1 Gouty exacerbation." mmary] " Resident ntibioticfor right foot [Nursing Note] "RT foot es pain." Physician's Note] "Follow up Peripheral Vascular grene. Hyperpigmentation m to touch and dry	F 7		ENCY)		
	(test that examines the arteries and veins in the diagnosis follow up. Dogreat toe (2) Wound go (2) Wound care cleans dressing pending vaso	X (diagnosis) (1) Toe pain reat toe RT nacrotic (sp). sing RT great toe and light cular consult."					
	08/24/22 [physician's or lower extremity [Dup follow up"	order] "Vascular consult for olex] for diagnosis and					

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION			E SURVEY MPLETED
		095020	B. WING			1	C 1/09/2022
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, 1818 NEWTON ST. WASHINGTON, I		<u> </u>	110012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH	OVIDER'S PLAN OF CORRECTIO I CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 776		[Physician's Assistant Note]	F	76			
	changing color with g	that pt's right foot toes are particular angrene Pt was gh phone translator Order al/venous US (ultrasound) to					
		I [Nursing Note] "Dynamic ppler will be done tomorrow done on 09/24/22"					
	09/23/22 [physician's arterial\venous right le	order] "Duplex Doppler eg and left leg"					
	procedure: venous De	Dynamic Mobile Imaging oppler bilateral findings: d is normalno evidence of					
	#26] was seen today the wound team in ho perfusing right toes is	chemic 1st, 4th and 5th toe ntment and leave open to					
	"Pt's nurse reported the results that need to be Imaging: Venous Dextremities) shows no	Physician's AssistantNote] nat pt had Doppler Scan e reviewed and addressed oppler bilateral LE (lower evidence of venous clots current treatment plan and					
	10/01/22 [physician's extremities arterial Do	order] "Bilateral lower ppler"					
	10/01/22 at 10:00 PM	[Nursing Note] " Bilateral					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCT			SURVEY PLETED
AND I WILL C.	OOMACHON	DERTH TOTAL COMBER	A. BUILDI	NG			
		095020	B. WNG			i	C / 09/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE	1	TOULL
				1818 NEWTON			
STODDAF	RD BAPTIST NURSING H	OME		WASHINGTO			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 776	Continued From page	e 105	F	776			,
	lower extremities arte result pending"	erial Doppler done this shift,					
		[Dynamic Mobile Imaging] I legs bilateral venous					
		ate plaque is noted within					
		Findings consistent with ut occlusion, right lower					
	extremity Moderate	stenosis between right					
	•	ry and mid SFA (superficial					
	femoral artery). Mode distal SFA"	erate stenosis of the right					
	_	[Vascular Consult Note] "					
	presents with gangrer extending to the midfo	ne of the right foot pot no realistic chance of				İ	
	healing The only ch						
	below-knee amputatio	on The patient and family					
	do not wish to have m	ajor amputation"					
		I that facility staff failed to					
	obtain the ordered dup timely manner. The du	plex for Resident #26 in a					
	08/24/22. A venous du						
		/22 (totaling 31 days later),					
1		nce of venous clots. Within					·
1	this timeframe (31 day						
		ecame ischemic (1st, 4th rial duplex was then done					
	•	later) that showed PVD with					
	, .	the right lower extremity.					
		ular consult completed on					
		, "gangrene of the right foot					
	_	dfoot no realistic chance choice for her would be					
	below-knee amputation						
	During a face-to-face i	interview conducted on					
	11/09/22 at 11:08 AM,	, Employee #2 (Director of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		SURVEY PLETED
,,,,,			A. BUILDI	NG _			
		095020	B. WING			1	C
NAME OF B	ROVIDER OR SUPPLIER	033020	1 0, ,,,,,		TREET ADDRESS OF COATE TO CORE	111	/09/2022
NAMEOFF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	OME			818 NEWTON ST. NW		
				W	VASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI:		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
		·			DEFICIENCY)		
F 776	Continued From page	106	F	776			
	Nursing/DON), #11 (0	Clinical Educator), and #12			F 812 – food procurement,		
	(Director of Quality Im	provement) were made			storage and preparation		
	aware of the findings	that Resident #26 did not			Storage and preparation		
	receive the necessary	care and required services			1. All items that were not		
	for her right foot, caus	sing a negative outcome.			labelled or dated were		
	They all acknowledge						
F 812	Food Procurement,St	ore/Prepare/Serve-Sanitary	F8	312	immediately discarded.		
SS=E	CFR(s): 483.60(i)(1)(2	2)			2. Refrigerator was checked		
					for any food items that		
	§483.60(i) Food safet	y requirements.			were not labelled or		
	The facility must -				dated. There were no		
					other food items found		
	§483.60(i)(1) - Procur				without label or date.		
		ed satisfactory by federal,			All dietary staff were		
	state or local authorities				provided an in-service on		
	-	ood items obtained directly			Food storage practices to		
		subject to applicable State			address proper labelling	ļ	
	and local laws or regu			l	of stored food items by		
		s not prohibit or prevent oduce grown in facility			Dietary Director.		
	- -	mpliance with applicable			4. Weekly random check on		
	safe growing and food				food storage will be		
		s not preclude residents			conducted by dietician		
		not procured by thefacility.			and reported to QAPI		
	sansanning roods	produce by morading.			monthly.		
	§483.60(i)(2) - Store, į	orepare, distribute and			5. Completion date: January		
	serve food in accordar				•		
	standards for food ser				9, 2023		ľ
		is not met as evidenced			Registered Dietician		
	by:						
		is and staff interview, facility					ļ
	staff failed to store and	· · · · · · · · · · · · · · · · · · ·					
		evidenced by food items					
		e (1) container of potato					ļ
		5) containers of mashed					ļ
		ne (1) pan of vegetable mix					
	noodles, one (1) of one	e (1) pack of turkey					
	bologna, one (1) of one	e (1) box of American					l
							-

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT			E SURVEY PLETED
		095020	B. WING _	****		i	C /09/2022
	ROVIDER OR SUPPLIER	HOME			ESS, CITY, STATE, ZIP CODE		10312022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	that were not labeled (1) walk-in refrigerator convection ovens, on oven that was soiled one (1) of one (1) flat both sides, and food below 135 degrees F six (6) observations. The findings included During a walkthrough October 31, 2022, at following were observed 1. Food items such as container of potato sa containers of mashed one (1) of one (1) p noodles, one (1) of or box of American ch pack of roast beef, all (1) of one (1) walk-in refrigerator 2. Two (2) of two (2) of soiled on the inside w 3. One (1) of one (1) of on the interior and ext residue and splashes.	of one (1) pack of roast beef, or dated in one (1) of one or, two (2) of two (2) soiled in (1) of one (1) Alto-Shaam on the interior and exterior, it top grill that was stained on temperatures that tested ahrenheit (F) on five (5) of it: It of dietary services on approximately 9:30 AM, the red: Is one (1) of one (1) alad, five (5) of five (5) it potatoes, oan of vegetable mix in e (1) pack of turkey in e (1) eese, and one (1) of one (1) stored on shelves in one in were not labeled or dated. Convection ovens were ith burnt foodresidue. Alto-Shaam oven was soiled terior with cooked food	F	1. 2. 3. 4.	The 2 convection ovens Shaam oven and flat top were immediately cleaned. All other kitchen applian were checked for cleanineeds. There were no ckitchen appliances in necleaning. All dietary staff were proan in-service on cleaning procedures and cleaning schedules. Weekly inspection of kitcappliances will be donedietician and reported to monthly. Completion date: Januar 2023 Registered Dietician	o grills ed. ces ng other ed of vided chen by the QAPI	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCT		СОМЕ	SURVEY PLETED
		095020	B. WING _				C /09/2022
STODDAI (X4) ID PREFIX	(EACH DEFICIENC)	OME ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	1818 NEWTON WASHINGTO	N, DC 20010 PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
	Continued From page November 3, 2022, at foods such as puree rice (133 degrees F (132 degrees Fahrenheit), collard greens (101 sweet potatoes (105 o below recommended ho temperatures of 135 o These observations w Employee #6 during a October 31, 2022, at a and on November 3, 2 PM. Resident Records - Id CFR(s): 483.20(f)(5), §483.20(f)(5) Resident (ii) A facility may not re resident-identifiable to accordance with a con agrees not to use or d except to the extent th to do so. §483.70(i) Medical rec §483.70(i) (1) In accord professional standards	e 108 It approximately 1:30 PM, hot Fahrenheit), puree peas neit), brussels sprouts (98 Idegrees Fahrenheit), and Idegrees Fahrenheit) tested It foods minimum Idegrees Fahrenheit. Idere acknowledged by Inface-to-face interview on Improximately 10:00 AM Idegrees, at approximately 2:00 Infiable Information Idease information that is Inface inface information that is Inface inface information that is Inface inface inface inface inface inface inface inface inface inface inface in	F 8	12 1. 2. 3. 4.	Hot foods were below re serving temperatures. If foods were heated in microwave as needed. All subsequent meals tewere within required temperature. Dietary staff were provide in-service to ensure food are delivered to the reside with required temperature. Review of test trays logged done weekly by QAPI Diand reported at monthly meetings. Completion date: 1-9-20 Director of QAPI	quired lot sted ed an l/trays dents es. will be rector QA	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED		
		095020	B. WING					C /09/2022		
NAME OF B	ROVIDER OR SUPPLIER		1	CTD	ET ADD	DDEER CITY STATE ZID CODE	1 11	10912022		
NAME OF P	ROVIDER OR SUPPLIER					DRESS, CITY, STATE, ZIP CODE				
STODDAF	RD BAPTIST NURSING H	OME				ON ST. NW				
				WAS	SHINGT	TON, DC 20010				
(X4) ID		ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	1	/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG			(EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE		
F 842	Continued From page	÷ 109	F8		3-1	D 11 (#70)				
	§483.70(i)(2) The faciall information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health a neglect, or domestic vactivities, judicial and law enforcement purp purposes, research purp purposes, research purp purposes, research purp purposes, research purp purposes, research purp purposes, research purp purposes, research purp a serious threat to heat by and in compliance §483.70(i)(3) The facili record information again unauthorized use. §483.70(i)(4) Medical for- (i) The period of time record in formation requirement is no requirement.	lity must keep confidential ned in the resident's records, in or storage method of the release istrateir resident permitted by applicable law; ment, or health care ed by and in compliance activities, reporting of abuse, riolence, health oversight administrative proceedings, oses, organ donation arposes, or to coroners, ineral directors, and to avertalth or safety as permitted with 45 CFR 164.512. It must safeguard medical ainst loss, destruction, or records must be retained required by State law; or a date of discharge when at in State law; or as after a resident reaches			3.	Resident #79's record was updated on 11/4/22 to indicate which arm should be used for blood pressure readings. There were no negative outcome for Resident #79. One other resident on dialysis had his blood pressure taken on the correct arm. The Nurse Educator provided all nursing staff an in-service on care for residents on dialysis to include where to safely obtain blood pressure readings on residents with AV graft sites for dialysis. The Nurse manager will conduct blood pressure observations at one random day/week until 100% compliance is sustained for 3 months. Findings will be reported to QAPI. Staff who are observed to be out of compliance will be reeducated and subject to				
	(i) Sufficient informatio(ii) A record of the resi(iii) The comprehensivprovided;	lical record must contain- in to identify the resident; dent's assessments; e plan of care and services preadmission screening				educated and subject to progressive discipline. Completion date: January 9, 2023 Director of Nursing				

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRU			(X3) DATE SURVEY COMPLETED			
		095020	B. WING			C 11/09/202	2
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, 1818 NEWTON ST. NW WASHINGTON, DC 20		111031202	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		ETION
F 842	and resident review edeterminations conductory. Physician's, nurse professional's progressional's progressional's progressional's progressional's progressional's reports as real This REQUIREMENT by: Based on record revione (1) of 41 samples failed to accurately domedical record. The findings included Review of the policy "Documentation" last resident who receives of complete and accurate record kept at all time should be documented and provided or as soon a completed " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled " Resident #79 was admobiled The physician and the following: A. The physician and the Director documented and The physician and the Director documented and The physician and the Director documented and The physician and the Director documented and The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The physician and the Director documented The Director documented The Director documented The Director doc	evaluations and stated by the State; 1's, and otherlicensed as notes; and ogy and other diagnostic equired under §483.50. It is not met as evidenced ew and staff interview, for different in Resident #79's example of the staff at [Facility Name] of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical care must have a definition of the staff at [Facility Name] elinical car	F	442			

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE COMP	SURVEY
				_			(С
		095020	B. WING _				11/	09/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
CTODDAG	RD BAPTIST NURSING H	ONE	ŀ	18	318 NEWTON ST. NW			
STUDDAN	RD BAPTIST NURSING H	OME		W	ASHINGTON, DC 20010			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE	CTION		(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
					A. Resident #79			
F 842	Continued From page	± 111	F8	42	Physician inadvertently wrote a			
	actively in the facility.				note on the wrong re			
	,				physician document	ed the	note	
	07/23/22 at 10:57 PM	[Nursing Note] "Resident			was written in error	on 12/	16/22.	
		ergency room) via 911. MD			The therapeutic recr	eation	aide's	
	(medical doctor) made	- ,			quarterly note was v	vritten	for the	
	,	prior 3 months but was v		∕as wri	tten			
	07/24/22 at 2:51 AM [Nursing Note] "Call placed			while the resident w	as out	of the	
	to [Hospital Name] in	ref (reference) to resident			facility. The TR aide	note:	was	
	status, Writer was told by charge that resident invalidated on 12/16/22.			/22. T	here			
	was admitted. No furth	vas admitted. No further information given" were no negative outcome this resident as a result of		tcome	s for			
				sult of	this			
	08/05/22 at 12:34 PM [Quarterly Therapeutic				deficient practice.			
	Recreation Note] "[Re				A review of all reside	ents		ļ
	knowledge of his self-				transferred to the ho	spital	was	
		eeds and desires. Resident			conducted. On 12/2	2/22 b	y the	
		nt activity participation			Health Information N	/lanage	er to	
	empowered to make h				identify similar error.	Ther	e were	
		e also provided to buttress			no other residents a	ffected	l by	
		ngagement. Resident is			this deficient practic	∍.		
	reticent in speech; yet				The Administrator pr	ovided	d an	
		v. It is a pleasure to interact			re-education on acc			
	with [Resident #79]"				documentation. The	Direc	tor of	
	08/16/22 at 12:31 PM	[Physician's Note]			Therapeutic Recreat			
		Note. Date: 8/16/2022			provided the TR staf		- 1	
	68-year-old Caucasiar				on documentation of	quarte	erly	
	facility since May of 20				notes on residents w	/ho are	not in	
		nd has remained stable			the facility at the time			
		new issues regarding his			quarterly note is due	on		
		emarkable. Lungs: Clear to			12/14/22.			
		ssion. CardiovascularS1			Physician entries an			l
	and S2 (heart sounds)				recreations notes on			l
		w issue regarding his care.			who are away from t			
		irrent management. Plan:			be monitored by the		۱	1
	Remains clinically stat				Information Manager			
		of Physician], MD Attending			reported to QAPI mo			į
	Physician."	-			Completion date: 1-			
					Health Information I	Vlanaç	ger	
	09/22/22 at 10:04 PM	[Nursing Note] "[Resident						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095020	B. WING		1	C 1/09/2022	
	ROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	#79] re-admitted from 1:35 pm" The evidence showed documented to doing and a physician's asseven though he was been though he was been though he was been though he was been though he was been though he was been though he was been though a face-to-face 11/07/22 at 9:50 AM, Nursing/DON) acknown adde no further commode in the commode of the com	d that facility staff a therapeutic assessment essment on Resident #79 hospitalized from 07/23/22 to interview conducted on Employee #2 (Director of wledged the findings and ments. R 3231.12 to accurately document the ent #79's blood pressure [Nursing Note] "[Resident om [Hospital Name] at order] "Resident is for y, Wednesday, Friday" MDS dated 09/27/22 orded: severe cognitive red dialysis while a resident. Nursing Note] "Left for AV (arteriovenous) graft [Nursing Note] "Resident e unit at 7:10 pmLeft arm graft site] observed with	F 84	42			

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		095020	B. WING_			11/09/2022	
	OVIDER OR SUPPLIER D BAPTIST NURSING H	OME		STREET ADDRESS, CITY, STATE, ZIP CO 1818 NEWTON ST. NW WASHINGTON, DC 20010	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	on the following dates documented to taking pressure on the left ar 10/28/22 at 06:10 AM 10/28/22 at 10:59 AM 10/28/22 at 10:59 PM 10/29/22 at 1:43 AM 10/29/22 at 1:47 PM 10/30/22 at 12:05 PM 10/31/22 at 10:57 AM 11/03/22 at 6:19 AM 11/05/22 at 4:39 AM 11/05/22 at 10:43 AM 11/05/22 at 10:43 AM 11/06/22 at 10:04 PM 11/06/22 At 10:04 PM 11/06/22 At 10:04 PM 11/06/22	79's vital signs showed that and time, facility staff the resident's blood m: s, facility staff recorded 9's blood pressure on the enterview conducted on Employee #2 (Director of 'The nurses know not to	F8	342			
F 867 C	arm]." API/QAA Improveme FR(s): 483.75(c)(d)(e		F 86	67			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRU	ICTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 867	Continued From page	114	F 86	7	- QAPI Improvement Activiti	es	
	policies and procedur collections systems, a adverse event monitor procedures must include following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representative information will be use are high risk, high voltor opportunities for improcessive	maintenance of effective use of feedback and input other staff, residents, and es, including how such ed to identify problems that ume, or problem-prone, and overment. maintenance of effective understand use data and expartments, including but the assessment required at ing how such information or and monitor performance development, monitoring, ormance indicators, logy and frequency for such			members were provided an in-service on the Quality Assurance and Performance improvement process by the Executive Clinical Director on 12/22/22. Training on QAPI will be provided to all staff across all departments. The identified areas in the statement of deficiency will be reviewed at each QA meeting. The Quality Council will evaluate finding to determine effectiveness actions for each aspect of care and services to determine how long to monitor each aspect of care	n ce ie s.	
	prevent adverse event §483.75(d) Program sy						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			11/09/2022	
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F 867	systemic action. §483.75(d)(1) The factorial aimed at performance implementing those at and track performance improvements are reased. §483.75(d)(2) The factorial provements are reased. §483.75(d)(2) The factorial provements are reased. §483.75(d)(2) The factorial provement policies and (ii) How they will use at determine underlying impacting larger system (iii) How they will deverwill be designed to efficient to prevent quality safety problems; and (iii) How the facility with of its performance improvem galaxies. Program at \$483.75(e) (1) The fact performance improvement in those at outcomes, resident saresident choice, and quality safety problems in those at outcomes, resident saresident choice, and quality safety problems in those at outcomes, resident saresident choice, and quality safety problems in those at outcomes, resident saresident choice, and quality in the safety problems in those at outcomes, resident saresident choice, and quality in the safety problems in those at outcomes, resident saresident choice, and quality in the safety problems in those at outcomes, resident saresident choice, and quality in the safety problems in those at outcomes, resident saresident choice, and quality in the safety problems.	cility must take actions a improvement and, after ctions, measure its success, at to ensure that alized and sustained. cility will develop and dressing: a systematic approach to causes of problems ams; lop corrective actions that act change at the systems of care, quality of life, or all monitor the effectiveness provement activities to ents are sustained. cility must set priorities for its ment activities that focus on or problem-prone areas; and affect health fety, resident autonomy, uality of care.	F	867			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
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		095020	B. WING			11/	09/2022
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			
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F 867	§483.75(e)(3) As part improvement activities distinct performance in number and frequency conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysis (c) and (d) of this section and (d) of this section (e) and (d) of this section (e) of this section. The functioning as a governativities, including improgram required under the comprehensive activities and the comprehensive quality performance improvement inclusive of all systems identify areas for improvements activity areas for improvements and implements their performance s, the facility must conduct improvement projects. The y of improvement projects lity must reflect the scope facility's services and its reflected in the facility at §483.70(e). must include at least it focuses on high risk or identified through the data is described in paragraphs ion. sessment and assurance. ality assessment and reports to the facility's signated person(s) iming body regarding its plementation of the QAPI er paragraphs (a) through the committee must: ment appropriate plans of fied quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on the improvements. It is not met as evidenced the wey, the facility failed to an effective, assurance and	F	867				

F CORRECTION	IDENTIFICATION NUMBER:	1				E SURVEY IPLETED
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The resident census of The findings included Facility staff failed to appropriate plans of a quality deficiencies as Under §483.12(b)(2), Abuse/Neglect Policie Under §483.12(c)(2), Investigate/Prevent/C Under §483.21(b)(1), Plan of Care Under §483.21(b)(3)(i Timing and Revision Under §483.24, F 684 Under §483.25(b)(1) (Treatment/Services to Ulcers On 11/08/22 at 2:16 Pwas conducted with E (Administrator) and #1 Improvement) regarding and Performance Implemployee #12 stated, every month except Addepartment heads and participate."	during the survey was 101. develop and implement action to correct identified a follows: F 607 Develop/Implement as F 610 are Alleged Violations F 656 Develop/Implement A Guality of Care Quality of Care (i)(ii), F 686 A Prevent/Heal Pressure M, a face-to-face interview apployees #1 2 (Director of Quality and the Quality Assurance rovement (QAPI). "The committee meets august and December. All a some direct care staff Alloyee #12 explained,	F	867			
"Documentation is son	nething we have reviewed					
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H SUMMARY ST (EACH DEFICIENCY REGULATORY OR I Continued From page The resident census of a quality staff failed to appropriate plans of a quality deficiencies as Under §483.12(b)(2), Abuse/Neglect Policie Under §483.12(c)(2), Investigate/Prevent/C Under §483.21(b)(1), Plan of Care Under §483.21(b)(3)(i) Timing and Revision Under §483.24, F 684 Under §483.25(b)(1) (Treatment/Services to Ulcers On 11/08/22 at 2:16 P was conducted with E (Administrator) and #1 Improvement) regarding and Performance Implement Performance	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 117 The resident census during the survey was 101. The findings included: Facility staff failed to develop and implement appropriate plans of action to correct identified quality deficiencies as follows: Under §483.12(b)(2), F 607 Develop/Implement Abuse/Neglect Policies Under §483.12(c)(2), F 610 Investigate/Prevent/Correct Alleged Violations Under §483.21(b)(1), F 656 Develop/Implement Plan of Care Under §483.21(b)(3)(i), F 657 Plan of Care Timing and Revision Under §483.24, F 684 Quality of Care Under §483.25(b)(1) (i)(ii), F 686 Treatment/Services to Prevent/Heal Pressure Ulcers On 11/08/22 at 2:16 PM, a face-to-face interview was conducted with Employees #1 (Administrator) and #12 (Director of Quality Improvement) regarding the Quality Assurance and Performance Improvement (QAPI). Employee #12 stated, "The committee meets every month except August and December. All department heads and some direct care staff	ROVIDER OR SUPPLIER RD BAPTIST NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 117 The resident census during the survey was 101. The findings included: Facility staff failed to develop and implement appropriate plans of action to correct identified quality deficiencies as follows: Under §483.12(b)(2), F 607 Develop/Implement Abuse/Neglect Policies Under §483.21(b)(1), F 656 Develop/Implement Plan of Care Under §483.21(b)(3)(i), F 657 Plan of Care Timing and Revision Under §483.24, F 684 Quality of Care Under §483.25(b)(1) (i)(ii), F 686 Treatment/Services to Prevent/Heal Pressure Ulcers On 11/08/22 at 2:16 PM, a face-to-face interview was conducted with Employees #1 (Administrator) and #12 (Director of Quality Improvement) regarding the Quality Assurance and Performance Improvement (QAPI). 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	"We look at late entri- staff not putting in an performed [CNA (Cer documentation, TAR Record)]. Managers a back to QAPI. There reported." - Skin Assessments: assessments are revi- the CNA documentati- sure wounds aren't de assessments are don all residents and docu [an electronic form to resident's skin]. For th assessments, the nur performing the shower inspection of the resid- does a more compreh the resident refuses th bath, the shower shee [the refusal] but the sl the same and should asked if the QAPI con issues with the facility assessments, Employ not aware that facility resident skin assessm scheduled shower day - Care plans: Employe plans are reviewed as committee has not not	used to track the es, Employee #2 stated, es, discrepancies, holes like y information for tasks tified Nurse Aide) (Treatment Administration audit their units and report have been no problems Employee #12 stated, "Skin ewed in QAPI. We discuss ion; nursing notes, to make eteriorating. Skin e at least once a week on umented on the "Skin Sheet" document the condition of ne shower sheet ase goes with the CNA er, they both do a visual dent's skin and then nurse nensive skin assessment. If ne shower and gets a bed et form should reflect that kin assessment process is be completed." When nmittee has found any 's documentation of skin ee #12 stated that she was staff is not performing nents weekly or on ys. ee #12 stated that care part of QAPI and that the ted any issues with care olementation or revision.	F	867			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		(X3) DATE COMF	SURVEY
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STODDA	RD BAPTIST NURSING H	OME		18	818 NEWTON ST. NW			
• • • • • • • • • • • • • • • • • • • •				N	WASHINGTON, DC 20010			
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F 880 SS=D	are reported and an in Allegations and incide QAPI. We look for any When asked if there is ensure investigations Employee #12 stated Through interview with the time of the QAPI reporting that the Quality Assurfailed to identify areas and implement correct related to: investigation injuries of unknown or and resident care/treat non-pressure related infection Prevention & CFR(s): 483.80(a)(1)(s) \$483.80 Infection Control facility must establiant infection prevention and designed to provide a comfortable environmedevelopment and transidiseases and infection program. The facility must establiand control program (If a minimum, the following \$483.80(a)(1) A system reporting, investigating and communicable dispersions.	ons of abuse and neglect investigation must be done. Ents reports are part of y trends and patterns." It is a performance tracking to are thorough and complete, "No." In Employees #1 and #12 at review, it was determined ance committee/facility staff of or improvement, develop tive and preventive actions of allegations of abuse, rigin, resident care plans, atment for pressure and culcers/wounds. In Control (2)(4)(e)(f) (1) (1) (2)(4)(e)(f) (1) (2)(4)(e)(f) (2)(F8	380	 Employee #13 was sent back to the Nurreview medication a principles, resident's infection control produced to November 9, 2022. The Infection Control Nurse Educator condobservations of all manurses for compliant medication administ principles, residents infection control prind (handwashing/handstation). All licensed nursing provided an in-service medication administ principles, residents infection control prind (handwashing/handstation). Medication administ will be monitored more ported quarterly in Completion Date: Jacobs Infection Control Nurse Infection Control Nurse 	rse education is right and cedures of Nurse and cedures of Nurse and cedures of Nurse and cedures of rights and ciples of the cedure of the ce	ator to ation and andom n n n n n n n n n n n n n n n n n n n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 880	Continued From page 120		F 8	380			
	providing services under a contractual						
	_	pon the facility assessment					
	accepted national sta	to §483.70(e) and following ndards;					
	§483.80(a)(2) Written standards, policies, and						
	procedures for the program, which must include,						
	but are not limited to:	anno docimpod to identifi.					
	possible communicab	ance designed to identify le diseases or					
	infections before they can spread to other persons in the facility;						
		n possible incidents of e or infections should be					
	reported;	e or injections should be					
		smission-based precautions					
		ent spread of infections;					
	resident; including but	lation should be used for a					
	(A) The type and dura						
		fectious agent or organism					
	involved, and	office and the second					
		the isolation should be the le for the resident under the					
	circumstances.	ic for the resident under the					
		under which the facility					
		es with a communicable					
	disease or infected ski contact with residents						
	contact will transmit th	·					
	(vi)The hand hygiene p	procedures to be followed					
	by staff involved in dire	ect resident contact.					
		n for recording incidents					
	identified under the fac	•					
	corrective actions take	п ву те тасшу.					
	§483.80(e) Linens.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	Cross reference DCMI	R 3217.6					