PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY
			A. BUILDI	ING .	***************************************		С
		095020	B. WING			03/	20/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAR	RD BAPTIST NURSING H	OME		ŀ	1818 NEWTON ST. NW		
01000711	to bar not notion of				WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 000	INITIAL COMMENTS		F	000			
	conducted at this facil March 20, 2024. Survobservations, record in staff interviews. The fiday of the survey was included 41 residents. The following Complated DC~12523, DC~1221 DC~11474 The following Facility investigated: DC~12553, DC~1252 DC~12177, DC~1214 DC~12018, DC~1201 DC~11829, DC~11630 DC~11601, DC~11570 DC~11403, DC~11410 DC~11329 DC~11222, DC~11512 Citations are being cited DC~12523, DC~1217 DC~11996, DC~11872 DC~11512 After analysis of the fit that the facility was not requirements of 42 CF	ints were investigated: 8, DC~11951, DC~11872, Reported Incidents were 9, DC~12322, DC~12262, 4, DC~12133, DC~ 12113, 9, DC~11996, DC~11837, 6, DC~11637, DC~11598, 4, DC~11539, DC~11504, 7, DC~11383, DC~11377, 2 ed for: 7, DC~12018, DC~12019, 2, DC~11829, DC~11574, Indings, it was determined of in compliance with the FR Part 483, Subpart B, and					
	Requirements for Lon	g Term Care Facilities.					
_ABORATORY [DIRECTOR'S OR PROVIDERS	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
	Mary Da	roy			AMNISTRATOR		12/24

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.

Event ID: J35811

Facility ID: STODDARD

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION			E SURVEY PLETED
							С
		095020	B. WING			03	3/20/2024
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP 1818 NEWTON ST. NW WASHINGTON, DC 20010	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B		(X5) COMPLETION DATE
	The following is a dire and/or acronyms that report: AMS - Altered Mental ARD - Assessment R AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federa CMS - Centers for Me Services CNA- Certified Nurse CRF - Community Re	ectory of abbreviations amay be utilized in the status eference Date Il Regulations edicare and Medicaid Aide sidential Facility stered Nurse Practitioner mbia umbiaMunicipal Mental Health Health Health sing artment cardiogram dical Services (911) m ncident tube es Center eation/Air conditioning ity	F				

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	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY IPLETED
		095020	B. WING			03	C 3/20/2024
	ROVIDER OR SUPPLIER	IOME		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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	IPCP - Infection Prev LPN - Licensed Pract L - Liter Lbs - Pounds (unit of MAR - Medication Ad MD - Medical Doctor MDS - Minimum Data Mg - milligrams (metr M - Minute ML - milliliters (metric Mg/dl - milligrams per Mm/Hg - millimeters of MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire NP - Nurse Practitions O2 - Oxygen PA - Physician's Assis PASRR - Preadmission Review Peg tube - Percutanes Gastrostomy PO - by mouth POA - Power of Attorr POS - physician's ord Prn - As needed Pt - Patient Q - Every RD - Registered Dietit RN - Registered Nurse ROM - Range of Motic RP R/P - Responsible	ention and Control Program ical Nurse mass) ministration Record Set ic system unit of mass) system measure of volume) deciliter of mercury Protection Association er stant on screen and Resident ous Endoscopic ney ersheet ian e on party deground, Assessment, enter	F	000			

Facility ID: STODDARD

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095020	B. WING		C
NAME OF PE	ROVIDER OR SUPPLIER	093020	B: Wiito	STREET ADDRESS, CITY, STATE, ZIP CODE	03/20/2024
	10 113 211 011 001 1 21211			1818 NEWTON ST. NW	
STODDAR	D BAPTIST NURSING H	OME		WASHINGTON, DC 20010	
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 000		3	F 00	0	
	Ug - Microgram	•			
F 580 SS=D		jury/Decline/Room, etc.))(i)-(iv)(15)	F 58	0 F580: Notification of Changes	
				1. Residents #52 and # 243 no longer r	eside
	§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,			in the facility. However, on 4/12/2023, Security Guard was re-educated from h	nio
				supervisor regarding resident monitoring	
		her authority, the resident		elopement prevention protocols.	lg and
	representative(s) whe	•			
		ring the resident which		2. The Director of Nursing and nursing	
	results in injury and h	as the potential for requiring		completed a skin sweep on current res with no new skin issues identified on	idents
	physician intervention			3/22/2024.The Director of Performance	,
	, , -	ge in the resident's physical,		Improvement reviewed x-ray reports fo	
	mental, or psychosoc	ıaı status (that is, a ı, mental, or psychosocial		residents from the last 30 days. 2 of 5	
		reatening conditions or		resident records did not indicate physic had been notified. Nursing Staff notified	
	clinical complications			physician of x-ray results on both resident	
	(C) A need to alter tre	atment significantly (that is,		3/22/24. No new orders given.	
	a need to discontinue	•			
		erse consequences, or to		3.The administrator to develop Notificat	
	commence a new form (D) A decision to trans			Policy by 5/1/24 . Staff Development nu educate licensed staff on new policy by	
	resident from the facil	•		5/6/24. The Director of Nursing and	
	§483.15(c)(1)(ii).	ny do oposinou m		Interdisciplinary Team will review Elect	ronic
		fication under paragraph (g)		Health Records clinical dashboard daily	'. I I
		the facility must ensure that		monitor changes in residents condition	
	is available and provid	on specified in §483.15(c)(2) ded upon request to the		require physician notification, and valid that notification occurred beginning 5/1	
	physician.			4. Validation results will be reported via	QA
	. ,	also promptly notify the lent representative, if any,		tool to QAPI committee monthly. (5/14/	
	when there is- (A) A change in room	or roommate assignment		5. Completion date 5/17/2024.	
	as specified in §483.1			6. Title of the person responsible noted	
		ent rights under Federal or		throughout POC	
		ns as specified in paragraph			
	(e)(10) of this section.	ecord and periodically			
	(iv) The lacility must f	ecord and periodically			

	F CORRECTION	iDENTIFICATION NUMBER:	1 ' '	NG		COMPLETED
		095020	B. WING			C
NAME OF F	PROVIDER OR SUPPLIER	033020] 2. VIIII	STREET ADDRESS, CITY, STAT	E, ZIP CODE	03/20/2024
STODDA	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRI FICIENCY)	
F 580	update the address (rephone number of the representative(s). §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configurated locations that comprise part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revitwo (2) of 41 sampled failed to immediately uphysician or their representation are change in the reside physician intervention Resident #243. The findingsincluded: 1. Facility staff failed Resident #52's primar representative of a factor pressure ulcer/wound. Resident #52 was addressure ulcer/wound. Resident #52 was addressure ulcer/wound. Resident #51 was addressure ulcer/wound. Resident #52 was addressure ulcer/wound.	posite distinct part. A facility stinct part (as defined in in its admission agreement ion, including the various se the composite distinct of the policies that apply to en its different locations is not met as evidenced ew and staff interviews, for residents, facility staff notify the resident's primary esentative when there was ent's condition that required and Resident #52 and	F	580		

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 5 guardian as her Responsible Party (RP), substitute decision maker and emergency contact		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 5 guardian as her Responsible Party (RP), substitute decision maker and emergency contact				7 50.125.110		(С
STODDARD BAPTIST NURSING HOME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)			095020	B. WING		03/	20/2024
STODDARD BAPTIST NURSING HOME WASHINGTON, DC 20010	NAME OF	PROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 5 guardian as her Responsible Party (RP), substitute decision maker and emergency contact	STODDA	ARD BAPTIST NURSING F	HOME				
guardian as her Responsible Party (RP), substitute decision maker and emergency contact	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	E	(X5) COMPLETION DATE
A Significant Change in Status Minimum Data Set (MDS) assessment dated 02/02/24 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "07", indicating severe cognitive impairment; at risk for pressure ulcers/injuries; and had no unhealed pressure ulcers/injuries; and had no unhealed pressure ulcers/injuries, wounds, or other skin problems. A Wound Care Physician's Note dated 02/28/24 at 8:16 AM documented: "Wound rounds; Stage3 sacral decubits ulcer; moderate drainage with necrotic tissue and slough. Plan: clean with Dakins solution (used to prevent and treat skin and tissue infections), apply collagenase Santyl ointment (debridement ointment used on dead tissue) and dry dressing daily." A physician's order dated 03/01/24 at 3:32 PM directed, "Dakin's 1/2 strength External Solution 0.25 %, cleanse sacral ulcer with Dakin's solution, pat dry, apply Santyl and cover with border gauze daily." A physician's order dated 03/01/24 at 3:38 PM directed, "Santyl External Ointment 250 Unit/GM (gram), apply to sacral ulcer topically every day shift for wound care." Review of the medical record from 02/28/24 to 03/01/24, approximately 48 hours, showed that facility staff failed to immediately notify Resident #52's primary care physician of a change in condition (stage 3 pressure ulcer). Additionally, as of 03/00/24 there was no documented	F 580	guardian as her Resp substitute decision m #1. A Significant Change (MDS) assessment d facility staff coded: a Status (BIMS) summa severe cognitive impa ulcers/injuries; and ha ulcers/injuries; and ha ulcers/injuries, wound A Wound Care Physic at 8:16 AM document sacral decubitus ulcenecrotic tissue and sle Dakins solution (used and tissue infections), ointment (debridement tissue) and dry dressi A physician's order da directed, "Dakin's 1/2 0.25 %, cleanse sacra solution, pat dry, apply border gauze daily." A physician's order da directed, "Santyl Exter (gram), apply to sacra shift for wound care." Review of the medical 03/01/24, approximate facility staff failed to in #52's primary care phy condition (stage 3 pre-	in Status Minimum Data Set ated 02/02/24 showed that Brief Interview for Mental ary score of "07", indicating airment; at risk for pressure ad no unhealed pressure ad, or other skin problems. cian's Note dated 02/28/24 ed: "Wound rounds; Stage3 r; moderate drainage with ough. Plan: clean with I to prevent and treat skin, apply collagenase Santyl at ointment used on deading daily." ated 03/01/24 at 3:32 PM strength External Solution al ulcer with Dakin's y Santyl and cover with ated 03/01/24 at 3:38 PM rnal Ointment 250 Unit/GM al ulcer topically every day I record from 02/28/24 to ely 48 hours, showed that neediately notify Resident ysician of a change in ssure ulcer). Additionally,	F 58			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		095020	B. WING		С
NAME OF	PROVERED OF CLUBBLER	095020	D. WING		03/20/2024
NAME OF	PROVIDER OR SUPPLIER		ŀ	STREET ADDRESS, CITY, STATE, ZIP CODE	
STODDA	ARD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW WASHINGTON, DC 20010	
(X4) ID	SUMMARY ST	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)	E COMPLETION
F 580	Continued From page	e 6	F 58	0	
	representative.		100		
	During a face-to-face 11:15 AM, Employee Nursing/DON) acknows tated, "Once a new oprocess is to immedia [primary] medical documents will write a progof the wound that includrainage, what the suand then also indicate notified." 2. Facility staff failed Resident #243's primare representative of an x left hip fracture. Resident #243 was according to the surface of	wledged the finding and wound area is observed, the stely call the resident's tor and get new orders. The press note with a description udes size, location, rrounding area looks like that the family was			
	Weakness, Other Abn Balance and Age-Reia				
	Review of Resident #2 revealed the following				
		ved the resident had a legal and emergency contact #1.			
		aff coded: a BIMS summary g mild cognitive impairment			
		cident (FRI), DC~11996, Agency on 05/29/23 at 6:30			
1			l .		1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
					·		С
		095020	B. WING			03	/20/2024
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	IOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW		
				٧	VASHINGTON, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 580	- At 4:40 PM, the rigive another resident step and fell on her leteration and fell accided the fall accided and fell accided the fall accided another resident step and fell on her leteration and fell accided accided and fell accided accided and fell accided and fell accided ac	resident got up on her seatto a hug and she missed her eff side. as called and gave an order ected leg. called and was made lent. dote dated 05/29/23 at 7:36 esident got up on her seatto a hug and she missed her fft side. as called and gave an order ected leg. called and was made ent. ted 05/29/23 directed, Left s dated 05/30/23 at 1:21 PM dislocation or degenerative dated 05/30/23 at 1:21 PM e of the neck of the proximal ant displacement. In and follow-up imaging cated. ote dated 05/30/23 at 2:01 ee #7 (Licensed Practical ted: knee done this shift, results cture, dislocation, or	F	580			

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		PLETED
							С
		095020	B. WING			03	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	IOME			818 NEWTON ST. NW		
0,022,				٧	WASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 580	Continued From page	e 8	F :	580			
	 Physician's Assis 	stant (PA) made aware;no					
	new order given.						
	It should be noted tha	at although Employee #7					
		received the results of the					
	left knee/hip x-rays, s	he failed to inform the PA of					
	the left hip fracture.						
	A Night Shift Nursing	Progress Note dated					
	05/31/23 at 6:56 AM	•					
	* *** -	of left hip x-rays with					
		placed fracture of neck of					
	left proximal femur. C						
	follow-up imaging indi	cated. Morning shift (day					
	shift, 7:00 AM - 3:30 F	PM) to follow-up with primary					
	physician.						
	A Night Shift Nursing	Supervisor Note dated					
		written by Employee #8					
	(Night Shift Nursing S	upervisor)documented:					
		x-rays received with					
	•	placed fracture of neck of					
	left proximal femur. C						
		cated. Please follow-up with					
	primary medical docto	л.					
	A Day Shift Nursing P	-					
	05/31/23 at 12:22 PM						
	•	rder given on 05/29/23 as					
	-	ee x-ray to rule out fracture.					
	the neck of the left pro	and indicated a fracture of					
	significant displaceme						
		e] made aware, neworder					
	given to transfer resid						
	emergency room for for						
		0 AM, resident left at 11:20					
	•	resentative made aware					
	before and after transf	fer.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		095020	B. WING		03/20/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW	
STODDAI	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)	
F 580		e 9 If that facility staff received	F 58	30	
	Resident #243's left hresults on 05/30/23 at shift (7:00 AM - 3:30 fdocumented evidence nurse, Employee #7, physician or represent	ip and left knee x-ray 1:20 PM, during the day PM). There is no that the assigned day shift made the resident's tative aware of the left hip ed "fracture of the neck of			
	assigned night shift no both documented that	owed that on 05/30/23, the urse and nursing supervisor. Resident #243's left hip re but neither notified the r her representative.			
	AM, 21 hours later, the	ary care physician and their			
	03/12/24 at 12:20 PM, Practical Nurse/LPN) when x-ray results are medical doctor with the she received both x-ray her progress note on 0 replied, "I don't remember 10 remember 11 remember 12:20 PM, and the reme	interview conducted on Employee #7 (Licensed stated, "The process for received is to call the e results. When asked if by results as documented in 05/30/23 at 2:01 PM, she aber. I talked about the left on't believe that I had both			
	AM, Employee #8 (Nig Supervisor) was asked notification made to Re their representative re				

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		00.5000	B. WING		С
		095020	B. WING		03/20/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
STODDA	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW	
				WASHINGTON, DC 20010	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	E (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)	
F 580	Continued From page	e 10	F 58	0	
	on-call list. Since I ha	ve been working here, the			
		to not call the medical			
	doctors during the nig				
	emergency and the p	atient is at risk of dying. We			
	wait until around 7:00	7:30 AM because most of			
	the doctors get angry	when we call them in the			
	middle of the night."				
	•	interview on 03/13/24 at			
	. , ,	#6 (Medical Director) stated,			
		chedule for the medical			
	· ·	ty, but I am available 24/7.			
	•	ning and night), nursing staff igned medical provider and			
		m, then they are to call me.			
		omes back with a fracture,			
	-	norning, that should be			
		Anything that affects the			
	resident's well-being s				
	_	ot been reported to me that			
	there are any issues v	vith reaching any of the			
		ing the evening or night			
	shifts."				
	ū	interview conducted on			
	· · · · · · · · · · · · · · · · · · ·	, Employee #2 (Director of			
	comment.	ed the findings and made no			
E 600		Noglaat	F 60		
	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F 60	7	
33=D	Or 11(3). 400.12(a)(1)				
	§483.12 Freedom from	n Abuse, Neglect, and			
	Exploitation				
		ight to be free from abuse,			
		tion of resident property,			
		fined in this subpart. This			
	includes but is not limi	ted to freedom from			
	corporal punishment, i	involuntary seclusion and			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	PLETED
						1	С
		095020	B. WING		 '	03	/20/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	IOME		1	818 NEWTON ST. NW		
				V	VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	e 11	F	600	F600 – Resident left facility without knowledge	ut staff	
	any physical or chem treat the resident's m	ical restraint not required to edical symptoms.			 Resident #192 no longer reside facility. Was unable to implemen corrective action. 		
	physical abuse, corpor involuntary seclusion; This REQUIREMENT by: Based on record revione (1) of 41 sampled failed to ensure Residneglect as evidenced facility without staff know the findings included Review of the policy to the finding findin	e verbal, mental, sexual, or bral punishment, or is not met as evidenced ews and staff interviews for diresidents, facility staff tent #192 was free from by the resident leaving the nowledge. It itled, Missing Resident ed, "A resident is om the facility whenever anot be ascertained. This ient." I dmitted to the facility on diagnoses including: ures, Muscle Weakness iver. I record revealed the			 The Director of Nursing (DON) completed elopement assessme on all current residents. Four residents were identified at risk delopement. Pictures and face sh were placed in Wanderers Book maintained at concierge desk on 4/26/24. The Administrator initiated mee with Security Supervisor to revier resident behaviors to include wandering, exit seeking, and oth behaviors requiring monitoring a intervention by security team on 4/22/24. Staff development nurs re-educate security team on miresident policy by 4/30/24. DON Interdisciplinary Team (IDT) will review clinical dashboard in EHF to monitor for any elopement act and to validate that staff response occurred per policy. 5/3/24. Validation results will be reported QAPI committee via QA tool and presented to QAPI committee mix 6 and on-going as necessary. Standard Policy 1/2/24. Completion date 5/17/24. 	etings etings etings ew ner and se will ssing and R daily etivity se ed to	On-going
	related to wandering e the elevator. Goal: Re Approach: Monitor res	192] has risk for Elopement evidenced by trying to enter sident will not elope. ident's movements closely burage resident to verbalize			Title of person responsible note POC.	d in	

Facility ID: STODDARD

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	, ,	E SURVEY PLETED
		095020	B. WING_			03	C 3/20/2024
	PROVIDER OR SUPPLIER	OME		181	REET ADDRESS, CITY, STATE, ZIP CODE 18 NEWTON ST. NW ASHINGTON, 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)	Ε	(X5) COMPLETION DATE
F 600	feelings of boredom/li- Encourage resident to activities of choice." A Quarterly Minimum assessment dated 02 following: a Brief Inter (BIMS) summary scoresident had an intact Additionally, the resides supervision from staff. A Facility Reported In (DC~11829) received was dated 04/04/23 a following but not limite in room 227B was not was alerted, all the ropink (Missing Resider called at 7:20am and information provided to comprising of nursing dispatched to search especially at the bus sesident [was] wearing white hooded top long Temperature outside a 7:30 am. MD (medical Nursing), and the respondified. Eventually we security that the police Investigation is still in Please note, According temperature in the Dis 04/04/23 during the date degrees (Fahrenheit).	Data Set (MDS) //12/23 documented the view for Mental Status of of "14", indicating the cognitive status. ent was coded for requiring with activities of daily living . cident Intake form by the State Agency that to 10:59 AM documented the ed to: "At 6:55 am, resident in his room. The security oms were searched. Code et) was initiated and 911 was residents detailed to the police. A search team staff and security were the community area, stops and metro stations. If you was a director, DON (Director of onsible party (ex-wife) was a got a call from the facility of found resident. The got World Weather, the	Fé	600			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
					С	
		095020	B. WING		03/20/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAI	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW		
01000	NO DAN TIOT WORKS IN			WASHINGTON, DC 20010		
(X4) ID	· · · · · · · · · ·		PROVIDER'S PLAN OF CORRECTION	1,		
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		
				DEFICIENCY)		
F 600	Continued From page	e 13	F 60	0		
i						
		ote dated 04/04/23 at 11:22 sident was received in bed				
	at 11:00 pm, alert, ori					
		utine round, Resident was				
		ght. Breathing even and				
		respiratory distress or				
	shortness of breath no	oted. No complain of pain or				
	discomfort voiced. Are					
		n cart down the hall to start				
		I normal start. Resident		·		
		n I got to his room at 6:40 edication, I could not see				
	-	throom, he was not there,				
		s and the supervisor , then				
		cer to found out if Resident				
	left the facility. The sta	affs(sp) begin to search for				
		hrooms. I left the facility				
	with other staffs in sea					
	bus-stops and metro s	stations."				
	A nursing supervisor r	note dated 04/04/23 at				
		d that, "At 6.55 am, I was				
		dent in room 227B was not				
		rity was alerted, all the				
		. Code pink was initiated.				
		am and information about				
	resident given. Search	rity were dispatched to				
	search for him around					
		s notified. [Responsible				
		ed, and she said [resident's				
	name] call(ed) her from	m bus stop around the				
		am converged around the				
		tually we got a call fromthe				
I	•	police found resident at a		·		
		ng to the facility, resident				
		ng lot accompanied by the				
	police officer. At this po	onit, residentrelused				

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		095020	B. WING _		C	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/20/2024	
STODDA	RD BAPTIST NURSING F	IOME		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	coming into the facility minutes to encourage come into the facility. name] returned to the encouragement. Resi verbally responsive, not to eassessment done. Noted. Skin warm to a and non-labored. Tem Respirations 18, Bloo Saturations 96%. Who from the facility, residing want to stay here and out again. New order one on one until seen Close monitoring in processing to the investigation of the facility. Period was time I saw [resident's name] was time I saw [resident's name] was time I saw [resident's name] facility. We did not find the facility. We did not find the following at 5:36 AM, at machine (kiosk) I walk security desk) leading a resident wearing a was bag was coming off owas going, and he staff	y, it took about 40 to 45 e and convince resident to At 8:50am, [Resident's e unit after much dent remains alert and ot in acute distress. Head to Denied pain, no discomfort and dry. Respiration is even apperature 98.0, Pulse 62, d Pressure 128/81, Oxygen en asked why he eloped ent stated that he does not verbalized that he will walk given to monitor resident by the psychiatricteam. ogress and maintained." stigation packet, the vrote statements dated documented, "I[employee's ht April 3, 2023, and assigned to me. The last name] was at 5:30 AM in es on the night shift on unit d went to the street and for him] after he left the I him."	F6			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY IPLETED
		095020	B. WING_			0.3	C 3/20/2024
	PROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		STREET ADDRESS, CITY, STATE, ZIP 1818 NEWTON ST. NW WASHINGTON, DC 20010	CODE		7.20,2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	TION SHOULD BI THE APPROPRI	_	(X5) COMPLETION DATE
	front desk area where Continued review of the packet showed Employmote an "Incident Redocumented, "[Reside [Facility name] at 6:44 [resident's name] was go look for [resident's returned to the nursing A psychiatric nurse pro4/05/23 at 6:58 PM of seen secondary to eldoreview of 1:1 monitoring have been here for too other facility that I coumonitoring. Alert and of time, and situation. Do psychiatric disorder. Pappears to make poor occasionally. Ambulate Continue 1:1 monitoring reassess for elopemer Encourage participation unit." A State Survey Agency (DC~11872) dated 04/documented: It was on April 4, 2 me at 7:00 AM stating home and was at a bus bus stop or where. I called the nursing my husband in the facilitold me that he's at a bus top or where at a bus and in the facilitold me that he's at a bus top or where at a bus and in the facilitold me that he's at a bus top or where at a bus and in the facilitold me that he's at a bus top or where at a bus and in the facilitold me that he's at a bus at a bus and a bus at a bus and in the facility and in the facility and in the facility at a bus at a bus and in the facility at a bus at a bus at a bus and in the facility at a bus at a bu	he facility's investigation byce #16 (Security Guard) port" dated 04/04/23 that ent daughter's name] called AM and confirmed at the bus stop. I went to name] at the bus stop and I g home at 7:20 AM." actitioner note dated locumented that, "Resident openent on 04/04/23 and ng order. [Resident stated] 'I to long; I was told at the lid leave.' Remains on 1:1 priented to place, person, wes not present with any leasant, not confused but and irrational judgement es with steady gait. In g every shift for now and int risk in 4-5 days. The facility's investigation in different activities on that the security is in the facility of the facility the facility o	Fé	600			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
					C
		095020	B. WING	1 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 -	03/20/2024
	PROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
	- I called [Resident MPD (Metropolitan Pophone and stated that Cener train station (at the facility) The officer agree went and picked him took him back to the real that this is a on the 2nd floor where allowing him to get out Review of Employee apersonnel record show on 05/16/22. The empthe Training Checklist he received training of desk unattended." Mosigned an "Employee 04/12/23 that docume 04/03/23 between 5AN name] you [were] supposted at the front des [resident's name] from lobby past the front dewhich caused an elope On 03/08/24 at approx observation of the lobb desk located adjacent At the time of the obse and receptionist were stone security staff. Additional binder labeled "Wande (where security staff wand concerns in the fact desk. The security logical states and receptions in the fact desk. The security logical states and security staff wand concerns in the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk. The security logical states are states and receptions to the fact desk.	t #192] back, an officer from blice Department) got on the they were at the Metro opproximately 3.1 miles from d to hold him. Mydaughter up from Metro Center and bursing home. In neglect on the staffthat's et he's on and security for t. #16's (Security Guard) wed the employee was hired bloyee signed his initials on dated 05/17/22 indicating in "Never leaving the front reover, the employee Warning Notice" dated inted that, "Date of incident of the 5:30 AM. [Employee's posed (sp) to been (sp) sk during this time room 227 walked thru the sk and out of the front door ement."	F 60		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				- I special and the control of the c	С
		095020	B. WING		03/20/2024
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW	
STODDA	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)	
F 600	on 04/04/23. During a telephone in AM, Employee #17 (N that Resident #192's informed her that staf resident (on 04/04/23 (Security Guard), who desk of the lobby, infosee the resident leave called a Code Pink ar resident with other state that he was wrough the believed when he behind the security defacility through the frostated that he was wrough desk unattended. He security guard to cove employee also stated report related to Reside thought he wrote the security logbook. During a face-to-face approximately 10:00 A Supervisor) stated that Guard) did not follow the left his post at from 04/04/23. He was to coin the building to cove reviewed that logbook see documented Resident	terview on 03/13/24 at 8:30 dursing Supervisor) stated assigned nurse called and f could not locate the). After Employee #16 o was posted at the front ormed her that he did not e out the front door, she and continued looking for the aff. terview on 03/13/24 at 9:30 fecurity Guard) stated that walked into the closet esk, the resident exited the not door. The employee fong for leaving the front should have called the other fer the front desk. The that he wrote an incident thent #192's elopement, and the information in the interview on 03/13/24 at AM, Employee #18 (Security the company's policy when the desk unattended on all the other security guard or his post. Employee #18 and stated that she did not ence that Employee #16 #192's elopement incident. ident should have been	F 60		

PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		095020	B. WING	- No.	03/20/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
STODDA	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW	
				WASHINGTON, DC 20010	
(X4) ID	ſ	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	-
				F607 Develop/Implement Abuse Policy	,
F 600	Continued From page	e 18	F 60	0 1. Residents #192 and #294 are no le	onger
				in the facility. Unable to retrospectiv	ely
E 00=		25 Quality of Care F689		correct deficient practice.	
F 607	• •	Abuse/Neglect Policies	F 60	2. The Assistant Bold completed	
SS=D	CFR(s): 483.12(b)(1)-	-(5)(II)(III)		head-to-toe assessments for reside	nts #25
	§483.12(b) The facilit	y must develop and		and #40 who were alleged to have engaged in resident-to-resident abu	uno No
		icies and procedures that:		injuries or other indication of abuse	
	implement written per	iolog and procedures that:		identified on either resident on	
	§483.12(b)(1) Prohibi	t and prevent abuse,		3/22/24. The DON completed elope	
	neglect, and exploitat			assessments on all residents. Four	•
	misappropriation of re	esident property,		residents were identified at risk of elopement. Pictures and face sheets	were
				placed in Wanderers book maintaine	
		sh policies and procedures		concierge desk on 4/1/24. Any reside	ent who
	to investigate any suc	ch allegations, and		is dependent for ADLs as well as res with history/behavioral of resident-to	
		training as required at		resident abuse has potential for this deficient practice. The DON and Dire	ector of
	paragraph §483.95,			Performance Improvement reviewed	
	8/83 12/h)//) Establis	sh coordination with the		resident documentation on 4/15/24 for	
	QAPI program require			previous quarter (January- March) are found no indications of abuse for the	
				other residents.	se oi
	§483.12(b)(5) Ensure occurring in federally-			3. Staff Development nurse will educa	
		e with section 1150B of the		staff including security team on residuate policy 4/22/24.DON and IDT v	
		procedures must include		review clinical dashboard in EHR da	
	but are not limited to t			monitor for any elopement activity as	nd to
				validate that staff responses occurre	d per
		ng a conspicuous notice of		policy 4/22/24 .	
		efined at section 1150B(d)		4. Validation results will be reported	
	(3) of the Act.			QAPI Committee quarterly via QA	tool
	\$492 12/h\/5\/;;;\ DL	ibiting and proventing		and presented to QAPI committee	nning
	§483.12(b)(5)(iii) Proh	at section 1150B(d)(1) and		monthly x6 and as necessary begi 5/14/24.	ining
I	(2) of the Act.	at section 11000(u)(1) and			
	This REQUIREMENT	is not met as evidenced		5. Completion date 5/17/24.	
	by:	ns, record reviews and		6. Title of person responsible noted in	1POC.
		views, for four (4) of 41			
	Tooldon and stan inter	7.5.7.5, 101 10d1 (7) 01 71			

Event ID: J35811

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		COMPLETED	
							С
		095020	B. WING _			03	/20/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, C			
STODDA	RD BAPTIST NURSING H	OME		WASHINGTON, DO			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX		IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-RE	FERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 607	Continued From page	e 19	F 6	07			
	sampled residents, fa						
	implement its policies						
	reporting and investig	ating allegations or displayed. Resident #192,					
		ent #25 and Resident #294.					
,	The findings included	:					
	A policy titled Prohibit	ion of Resident					
		tion (#99-12) documented					
	•	mited to: "Each resident has m neglect. Neglect- means					
	-	ds and services necessary					
	to avoid physical harm illness."	n, mental anguish, or mental					
		's policy titled "Resident					
		8/23/23, documented the ent has the right to be free					
	_	ounishment, and involuntary					
	seclusion. Residents	must not be subjected to					
	•	uding, but not limited to					
		dents" and "Abuse means njury" and "resulting in					
	physical harm, pain or						
	"Physical abuse include						
		and "Each resident has the iistreatment, neglect" and					
	"This includes the faci						
	residents, whose pers	onal histories render them					
	at risk for abusing other	er residents.					
	Identification						
		as suspicious bruising of					
	may constitute abuse;	s, patterns and trends that and to determine the					
	direction of the investig						
	Investigation						

P .	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		095020	B. WING	A STATE OF THE STA	03/20/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
STODDA	RD BAPTIST NURSING H	IOME	ļ <i>'</i>	1818 NEWTON ST. NW	
			١ ،	WASHINGTON, DC 20010	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	l	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	1
		,		DEFICIENCY)	···-
F 607	Continued From page	20	F 607		
	Investigate different to		'00'		
		ber responsible for initial			
	_	n of alleged violations and			
		the proper authorities.			
	Protection				
	Protect residents from	n harm during an			
	investigation.				
	Reporting/Response				
		or witnesses an alleged			
	•	buse is required to report the			
		Supervisor or department			·
	head immediately. Th	e Nursing			
		nt head will immediately			
		on and give an oral report to			
	the Administrator."				
	1 The facility staff fail	ed to implement its policies			
		porting and investigating			
		s of abuse and neglect for			
	Resident #192.	3			
		mitted to the facility on			
	11/10/22 with multiple	•			
		ures, Muscle Weakness			
	and Cirrhosis of the Li	ver.			
	Review of the medical	record revealed the			
	following:				
	Ŭ				
	A Quarterly Minimum I	Data Set (MDS)			
	assessment dated 02/				
	following: a Brief Interv				
	(BIMS) summary score				,
	resident had an intact of				
		nt was coded for requiring			
	supervision from staff (with activities of daily living .			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	DATE SURVEY COMPLETED
					С
		095020	B. WING _		03/20/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
STODDA	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW	
				WASHINGTON, DC 20010	
(X4) ID	Į	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORREC	(X5)
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	COMPLETION DATE
				DEFICIENCY)	
F 607	Continued From page	21	F6	07	
	A Facility Reported In				
		by the State Agency that			
		t 10:59 AM documented the			
		ed to: "At 6:55 am, resident			
		t in his room. The security			
		oms were searched. Code nt) was initiated and 911 was			
	called at 7:20 am and	· ·			
		to the police. A search team			
	•	staff and security were			
	dispatched to search				
	especially at the bus s	stops and metro stations.			
	Resident [was] wearin	g a white sweat pants and			
	white hooded top long				
	- · · · · · · · · · · · · · · · · · · ·	at the time is 58 degrees at			
		director), DON (Director of			
		onsible party (ex-wife) was			
	security that the police	e got a call from the facility			
	Investigation is still in				
	mvestigation is still in	are process.			
	A nursing supervisor r	note dated 04/04/23 at		·	
	12:16 PM documented	d that, "At 6.55 am, I was			
		lent in room 227B was not			,
	in his room. The secur	•			
		Code pink was initiated.			
		am and information about			
	resident given. Search				
	search for him around	rity were dispatched to			
1		s notified. [Responsible			
		ed, and she said [resident's			
	name] call(ed) her from				
		m converged around the			
		tually, we got a call from			
		t the police found resident			
	at a bus stop. Upon ref				
	resident was found at t	the parking lot			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		095020	B. WING_			C 03/20/2024
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		03/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / 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)	LD BE	(X5) COMPLETION DATE
	accompanied by the president refused comiabout 40 to 45 minute convince resident to 68:50am, [Resident's rafter much encourage alert and verbally residistress. Head to toe pain, no discomfort not Respiration is even an Temperature 98.0, Publood Pressure 128/8 When asked why he resident stated that he and verbalized that he order given to monitor seen by the psychiatri progress and maintain A State Survey Agency (DC~11872) dated 04. documented: It was on April 4, 2 me at 7:00 AM stating home and was at a bubus stop or where. I called the nursin my husband in the facitold me that he's at a bubus stop he was number. I called [Resident MPD (Metropolitan Pol phone and stated that Cener train station (ap the facility). The officer agreed	colice officer. At this point, ing into the facility, it took is to encourage and come into the facility. At lame] returned to the unit ement. Resident remains consive, not in acute assessment done. Denied officed. Skin warm to and dry. and non-labored. Itles 62, Respirations 18, 1, Oxygen Saturations 96%. Peloped from the facility, at does not want to stay here as will walk out again. New are resident one on one until of team. Close monitoring in med." Ty Complaint Intake (10/23 at 3:30PM) 2023 [Resident #192] called that he's out of the nursing is stop and didn't know what ag home asking them was lity, because he called and ous stop. They asked me at and for his cell phone #192] back, an officer from ice Department) got on the they were at the Metro proximately 3.1 miles from to hold him. Mydaughter up from Metro Center and	F 6	507		

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION S		X3) DATE SURVEY COMPLETED
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		095020	B. WING			03/20/2024
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW		
				WASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRE		(X5) COMPLETION
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API		
				DEFICIENCY)		
F 607	Continued From page	23	F 60	07		
		a neglect on the staffthat's				
		e he's on and security for				
	allowing him to get ou	ıt.				
	During a face to face	intoniou on 02/09/24 of				
	-	interview on 03/08/24 at M, Employee #2 (DON)				
	• •	staff failed to implement				
	their prohibition of res			:		
	prevention policy whe	n Resident #192 eloped				
	from the facility withou	ut staff knowledge.				
	Cross reference 483.2	25 Quality of Care F689				
	2 The facility staff fail	ed to implement its policies				
		porting and investigating				
		s of abuse and neglect for				
	Resident #40 and Res					
	altercation.					
	During an observation	on first floor resident day				
	-	:14 PM, the following was				
	noted by two (2) State					
	Resident #25 was wal	king into the dayroom				
	toward Resident #40,					
		ng television. Resident #25				
		abbing the push handles of				
	Resident #40's wheeld	chair and pushing the esident #25 then started				
		n the left side of his body.				
		ed by attempting to raise				
		nits. At this time, three (3)				
		ing from the nursingstation				
	to the day room to sep	arate the 2 residents. The				
		mployee #23 (Registered				
		Resident #25 and another				
I .		ent #40 to the opposite				
	side of the dayroom.					
	2A. Resident #40 was	admitted to the facility on				

AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
			095020	B. WING			<u>ر</u>	C 3/20/2024	
		ROVIDER OR SUPPLIER	OME	I	STREET ADDRESS, CITY, STATE 1818 NEWTON ST. NW WASHINGTON, DC 20010	E, ZIP CODE			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B D TO THE APPROPRI CIENCY)	E	(X5) COMPLETION DATE	
		Other Seizures, Anen Personal History of O and Embolism. Review of Resident # revealed the following: A Quarterly MDS assorevealed that the facil resident's preferred lathe resident needs an with a doctor or health speech, sometimes may sometimes is able to unvision; Moderately implecision making; dependent of the medical making in the upper service of the medical not documented evideral altercation involving R #25 that was observed 03/05/24. 2B. Resident #25 was 11/10/22 with multiple following: Unspecified Status, Blindness Right Vision in Left Eye, and Deficit. Review of Resident #2 revealed the following:	e diagnoses that included: nia, Hypotension, and ther Venous Thrombosis 40's medical record g: essment dated 12/12/23, ity staff coded that the nguage is "Russia" and that interpreter to communicate n care staff; had unclear takes self-understood, nderstand others, impaired paired cognitive skills for endent on staff forself-care; chair and had no ter extremities. record showed there was nce of the physical esident #40 and Resident to by the facility's staff on admitted to the facility on diagnoses that included the Dementia, Altered Mental to Eye Category 5, Normal Cognitive Communication 5's medical record	F	607				
		01/30/24 showed that t	the facility staff coded:						ĺ

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER	095020	B. WIING	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03	/20/2024
STODDA	RD BAPTIST NURSING H	OME		1818 NEWTON ST. NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG			ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE		(X5) COMPLETION DATE
F 607	adequate hearing, cle self-understood, under highly impaired vision cognitive skills for dail symptoms not directe physical symptoms suself, pacing rummagir wandering, occurred impairment on the upper A nursing progress not perform the pacing and wandering to other responsive with internate the pacing and wandering to other responsive with internate the pacing and wandering to other responsive with internate the pacing and wandering to other responsive with internate the pacing and wandering to other responsive with internate the pacing and wandering to other responsive with internate the pacing and wandering to other responsive with internate the pacing and wandering to other responsive with internate the pacing progress not alternate the paci	ear speech, usually make erstands others, and had a severely impaired by decision making; behavior d toward others (e.g. auch as hitting or scratching ang), rejection of care, and a to 3 days; and no per or lowerextremities. The dated 03/05/24 at 5:56 sident is alert and verbally mittent confusion. Resident dering around the unit and sident's rooms. Resident a unit 2 times during the AM are exit door behind and also a dining area." The dated 03/06/24 at 10:28 are entry 3/5/25 [3/5/24] at dent #25] noted with redirected by staff to the tivities. Resident noted his writer redirected resident sident around unit for a second acked ence that the facility staff the observed resident to	F	607			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		095020	B. WING		03/20/2024
	PROVIDER OR SUPPLIËR RD BAPTIST NURSING H	OME		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 607	On 3/6/2024 at 10:30 interview Resident #4 up in bed and unable writer's baseline ques morning how are you? During a face-to-face 03/07/24 at 10:54 AM Nurse Aide) stated, "F goes into other reside people and he has hit on to say that Resider During a face-to-face 03/07/24 at 2:59 PM, know of any incidents (Resident #25) and he have followed the nec	AM during an attempt to 0; He was observed sitting to verbally respond to the tions such as, "Good ?" interview conducted on , Employee #30 (Certified Resident #25 is erratic he nt's rooms and he has hit me." Employee #30 went nt #25 is redirectable. interview conducted on Employee #2 stated, "I don't that occurred with a (Employee #23) should essary protocols (report the ion, notify physician and	F 60'		
	and procedures for repallegations or incidents Resident #294's allegated Resident #294 was ad 06/16/23 with multiple following: Hemiplegia at Cerebral Infarction Affe	mitted to the facility on diagnoses that included the and Hemiparesis following ecting the Non-Dominant f Sacral Region Stage 2, Type 2.			,

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	03/20/2024
STODDAI	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		ON SHOULD BE IE APPROPRIA	
	An Admission MDS a showed facility staff of Mental Status (BIMS) which indicates intact extensive assistance assist for bed mobility and toilet use; require one (1) person physic hygiene; was dependented the resident; and had the upper and lower edusorder/panic attack." A care plan focus area disorder/panic attack the following intervent with caution, explain a and encourage activity. A Nursing progress no PM, documented "Resverbally responsive." A living) cares provided, administered and toler fluids offered. Resider this shift." A Facility Reported Incoumented: Resident's wife called husband's head was hoare on the weekend (-"Writer went to reside	ssessment dated 06/21/23 oded: A Brief Interview for summary score of "15" cognition; required of two (2) person physical r, transfer, dressing, eating, ed extensive assistance of all assist for personal ent on staff for bathing and impairment on both sides in extremities. a of "Post-traumatic stress initiated on 07/20/23 had ions, "Approach resident ell procedures to resident, y. Report behavior." but dated 08/06/23 at 10:38 sident remain alert and And "ADL (activities of daily due medications rated well. PO (by mouth) at c/o (complained of) pain cident (FRI) DC~12177 was Agency on 08/07/23 that d writer and stated that her it on the wall 3 times during Sunday) 08/06/2023. ent's room accompanied by	F	607		
	day. When resident wa he stated, "I hit my hea when I was being char	vorked with him on the said as asked how it happened, ad on the bed rail 3 times aged." When asked if he he stated, "she cameand				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		095020	B. WING			С
NAME OF C	ROVIDER OR SUPPLIER	095020	B. WING _			03/20/2024
NAME OF F	NOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW		
STODDAI	RD BAPTIST NURSING F	IOME		WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	that she came into re routine medications we face because he had resident nodded his he cleaned my eyes and When asked if he told about his head, he state to say that his aide for A follow-up submission State Agency on 08/1 following: "Report of in on August 6th (2023), review with statement evidence of abuse or resident's complaint. (to remain stable, and resident before dischastication of physical at A review of the facility' related to this incident documented evidence Resident #294, notified resident's allegation of staff that worked the sallegation, and obtained residents.	sident's room, to pass his which she did after wiping his some crusts on his eyes. I lead and said "yes she gave me medications" I charge nurse at that time ated "no". Resident went on that Sunday was a male." In from the facility to the 7/23 documented the evestigation into the incident After thorough clinical s from staff, there was no neglect related to the Resident #294) continues all due care provided to the arge to the hospital." If the resident's medical ented of Resident #294's abuse by staff member are investigation packet wallegation, lacked that the facility assessed the physician of the fabuse, interviewed all the hift on the day of the enter interviews from other	F 6	07		
:	03/18/24 at approxima #2, (Director of Nursing	nterview conducted on tely 3:00 PM, Employee g) stated that the facility d, and she was not able to				

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		095020	B. WING			U3	C /20/2024
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE		72072024
STODDA	RD BAPTIST NURSING H	OME	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 607		documentation concerning	F	507	F 609 Reporting Alleged Violation 1. Residents #192 and #294 no longe in the facility. Was unable to retrospectively correct this deficient practice	r reside	
F 609 SS=D	CFR(s): 483.12(b)(5) §483.12(c) In respons	Violations	F 6	09	 The DON and Director of Performance Improvement reviewe resident investigations for previous (January – March) on 4/26/24. Investigations were reported within and outcomes of investigations wer documented. 	quarter 5 days	
	involving abuse, negle mistreatment, includir source and misappropare reported immedia hours after the allegati that cause the allegati serious bodily injury, of the events that cause abuse and do not resuthe administrator of the officials (including to the adult protective service for jurisdiction in long-accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated representa accordance with State Survey Agency, within incident, and if the allegappropriate corrective	ng injuries of unknown priation of resident property, tely, but not later than 2 ion is made, if the events on involve abuse or result in or not later than 24 hours if the allegation do not involve alt in serious bodily injury, to be facility and to other the State Survey Agency and the es where state law provides term care facilities) in the law through established the results of all diministrator or his or her law, including to the State 5 working days of the eged violation is verified			 The Administrator will develop an investigation policy and reporting form include reporting results by 5/1/24 to in timely reporting of investigations (within days) and reporting outcomes of investigations. Staff Development Nurre-educate all staff including security regarding Prohibition of Resident Abu. Abuse investigation. This includes represults of their investigation to the stawithin 5 working days of incident 5/10 Performance Improvement Director waudit investigations documentation in instances of alleged abuse and elope to validate policy compliance beginnin 5/11/24. Audit results to be reported to QAPI committee monthly by Performance Improvement Director beginning 5/14/25. Completion date 5/17/24. Title of person responsible noted in P 	clude in 5 rse will team use/ porting iff i/24. vill ement ng	On-going

AND PLAN OF CORRECTION		iDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
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NAME OF F	DROVIDED OF SUPPLIED	095020	B. WING	STREET ADDRESS, CITY, STATE	710 0005	03/20/2024
	PROVIDER OR SUPPLIER RD BAPTIST NURSING F	IOME		1818 NEWTON ST. NW WASHINGTON, DC 20010	, ZIP CODE	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD B D TO THE APPROPRI CIENCY)	
F 609	Based on record revitwo (2) of 41 sampled failed to report the rest the State Agency with the incident. Resident The findings included A review of a facility process of the sample of a facility process of the facility who is respanding to the facility who is respanding to the state of the sample of of	iews and staff interviews, for a residents, facility staff sults of their investigations to hin 5 (five) working days of at #192 and Resident #294. : colicy titled "Prohibition of the Prevention" revised on a the following: "The facility see prevention Coordinator in consible for reporting the dabuse, neglect or the survey agency and other the with state law" and "An consist is warranted when reglect or exploitation, or lect or exploitation occur. In investigations include: Insible for the investigation, andling evidence that could investigation (e.g. (for any or destroying evidence); types of alleged violations; rewing all involved persons, wictim, alleged perpetrator, who might have knowledge and to report the results of the ement incident to the State and days. Imitted to the facility on diagnoses including: ures, Muscle Weakness	F	509		

)	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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		095020	B. WING_		C	3/20/2024
NAME	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STOD	DARD BAPTIST NURSING I	HOME		1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) I PREF TAG	X (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 SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 6	Review of the medical following: A Facility Reported In (DC~11829) received was dated 04/04/23 at following but not limit in room 227B was no was alerted, all the ropink (Missing Resider called at 7:20am and information provided comprising of nursing dispatched to search especially at the busing Resident [was] wearing white hooded top long Temperature outside 7:30 am. MD (medical Nursing), and the respondified. Eventually we security that the police Investigation is still in A nursing supervisor in 12:16 PM documente informed that the residing his room. The securooms were searched 911 was called at 7:20 resident given. Search nursing staff and security in a search for him around stations. The DON was party's name] was call name] call(ed) her from facility. The search teacommunity area. Even	al record revealed the accident Intake form I by the State Agency that at 10:59 AM documented the ed to: "At 6:55 am, resident it in his room. The security froms were searched. Code ant) was initiated and 911 was residents detailed to the police. A search team staff and security were the community area, stops and metro stations. ag a white sweat pants and ag sleeve sweater. at the time is 58 degrees at I director), DON (Director of consible party (ex-wife) was ag got a call from the facility as found resident. The process." Inote dated 04/04/23 at at d that, "At 6.55 am, I was aftent in room 227B was not arity was alerted, all the and Code pink was initiated. It was alerted, all the and comprising of arity were dispatched to bus stops and metro s notified. [Responsible ed, and she said [resident's	F	509		

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		'E SURVEY IPLETED
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		095020	B. WING_		03	3/20/2024
	PROVIDER OR SUPPLIER ARD BAPTIST NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	bus stop. Upon return was found at the park police officer. At this police officer. At the police officer. As the police officer. At the police officer. At the police officer. At the police officer. At the police officer. A state officer. A s	ning to the facility, resident sing lot accompanied by the point, resident refused by, it took about 40 to 45 and convince resident to At 8:50am, [Resident's unit after much dent remains alert and ot in acute distress. Head to Denied pain, no discomfort and dry. Respiration is even apperature 98.0, Pulse 62, depressure 128/81, Oxygen en asked why he eloped ent stated that he does not verbalized that he will walk given to monitor resident by the psychiatricteam. Express and maintained." Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Express and maintained." Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Express and maintained." Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Express and maintained." Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Express and maintained." Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he does not verbalized that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he does not verbalized that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he does not verbalized that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he does not verbalized that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he will walk given to monitor resident by the psychiatricteam. Expression 128/81, Oxygen ent stated that he will walk given to monitor reside	F6	609		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	, ,	OMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	093020	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE		03/20/2024
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F 609	, 0	e 33 25 Quality of Care F689	F 6	09		
		led to report the results of Resident #294's allegation				,
	06/16/23 with multiple following: Hemiplegia Cerebral Infarction Af	dmitted to the facility on diagnoses that included the and Hemiparesis following fecting the Non-Dominant of Sacral Region Stage 2, Type 2.				
	Review of Resident #2 revealed the following					
	showed facility staff co	ssessment dated 06/21/23 oded: A Brief Interview for summary score of "15" cognition.				
	submitted to the State documented: - Resident's wife calle husband's head was heare on the weekend a "Writer went to reside the charge nurse that day. When resident whe stated, "I hit my he when I was being chartold the nurse about it, gave me my medicatio that she came into resroutine medications when the state of	ent's room accompanied by worked with him on the said as asked how it happened, ad on the bed rail 3 times nged." When asked if he he stated, "she came and ons." Charge nurse stated ident's room, to pass his nich she did after wiping his some crusts on his eyes.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		095020	B. WING		03/20/2024	
	PROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 609	cleaned my eyes and When asked if he told about his head, he state to say that his aide for A follow-up submission State Agency on 08/1 intake documented the investigation into the in	gave me medications" I charge nurse at that time ated "no". Resident went on I that Sunday was a male." In from the facility to the 7/23 10 days after the initial I e following: "Report of Incident on August 6th I clinical review with I there was no evidence of I ed to the resident's I e provided to the resident	F 60	9		
SS=E	03/18/24 at approxima #2, (Director of Nursin leadership has change locate any additional director of Resident #294's allegated Cross Reference 22B Investigate/Prevent/CoCFR(s): 483.12(c)(2)-(c) \$483.12(c) In response neglect, exploitation, omust: §483.12(c)(2) Have eviviolations are thorough	DCMR sec. 3269.1 brrect Alleged Violation 4) e to allegations of abuse, r mistreatment, the facility idence that all alleged	F 610			

l .	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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		095020	B. WING		03/20/2024
NAME OF F	PROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW	
STODDA	RD BAPTIST NURSING H	IOME		WASHINGTON, DC 20010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 610	investigation is in pro §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revi four (4) of 41 sampled failed to have docume conducted thorough in 192, 294, 244 and 63. The findingsincluded: Review of the facility's Resident Abuse/Abus 09/24/22 documented - Investigation: Identify involved persons inclualleged perpetrator ar knowledge of the alleg Review of a facility po Resident Abuse/Abus documented the follow "Neglect-means failure employees, or service and services to a resid avoid physical harm, p emotional distress. Inv and Neglect - Focusin determining if neglect	the results of all administrator or his or her ative and to other officials in e law, including to the State in 5 working days of the eged violation is verified e action must be taken. It is not met as evidenced ews and staff interviews, for diresidents, facility staff ented evidence that they investigations. Resident #'s exposed violation of e Prevention' revised evidence that they investigations. Resident #'s exposed violation of e Prevention (#99-12)" wing but not limited to: evidence that they exposed enter that are necessary to every exposed evidence that they exposed evidence that evidence evidence evidence that they exposed evidence that they exposed evidence that they evidence ev	F 6	10 1. Residents # 192, # 294 and #2 no longer reside in facility. DON reviewed investigation for reside #63 for incident that occurred of 6/9/23. Unable to retrospectivel implement corrective action for resident involved. 2. The Administrator reviewed all available incidents reported to E Health on elopement, verbal thr of harm or allegation of staff about for the quarter (January – March 2024) on 3/30 to determine if thorough investigations were conducted. Review validated that investigations were completed. 3. Administrator will develop investigation policy to include completion of thorough investigations by 4/30/24. Staff development will educate all staincluding Security team on new policy by 5/10/24. Interdiscipling Team will review investigations, if any during daily clinical meeting to validate policy compliance beginning 5/10/24. 4. Validation results will be report via investigation tool to QAPI committee monthly 5/14/24. 5. Completion Date 5/17/24. 6. Title of person responsible note POC.	ent n y any OC eats use 0/24 dons aff ary ed On-going

	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED
				<u> </u>	С
		095020	B. WING _	The second secon	03/20/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW	
STODDA	RD BAPTIST NURSING H	IOME		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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 610	A policy entitled, Miss documented in part, "assign personnel to s and equipment rooms the roof and basemer other furniture, beneavehicles and shrubbe 1. Facility staff failed evidence that they co investigations of Resi the facility. Resident #192 was as 11/10/22 with multiple	sing Residents (#99M-010) The Search Director is to earch the boiler, storage, i, laundry and kitchen areas, it, if any, beneath beds and ith stairways, parked ry." to have documented inducted thorough dent #192's elopement from dmitted to the facility on e diagnoses including: cures, Muscle Weakness iver.	F 6	DEFICIENCY)	
	A Quarterly Minimum assessment dated 02 following: a Brief Inter (BIMS) summary scor resident had an intact Additionally, the reside supervision from staff A Facility Reported In (DC~11829) received was dated 04/04/23 at following but not limite in room 227B was not was alerted, all the roopink (Missing Residen called at 7:20am and	view for Mental Status re of "14", indicating the cognitive status. ent was coded for requiring with activities of daily living cident Intake form by the State Agency that t 10:59 AM documented the ed to: "At 6:55 am, resident in his room. The security oms were searched. Code t) was initiated and 911 was			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		E CONSTRUCTION		PLETED
		005000	B MAINIC				С
		095020	B. WING			03	/20/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	IOME			1818 NEWTON ST. NW		
				1	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)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
170	7,2002770777		140		DEFICIENCY)		
F 610	Continued From page	e 37	F	610			
	, ,	staff and security were		0.0			
	dispatched to search						
		stops and metro stations.					
		ng a white sweat pants and					
	white hooded top long						
		at the time is 58 degrees at					
	7:30 am. MD (medica	I director), DON (Director of					
	Nursing), and the resp	oonsible party (ex-wife) was					
		e got a call from the facility					
	security that the police						
	Investigation is still in	the process."					
	•	d-td-04/04/00 -t					
	• .	note dated 04/04/23 at					
		d that, "At 6.55 am, I was					
		dent in room 227B was not rity was alerted, all the					
İ		l. Code pink was initiated.					
		Dam and information about					
	resident given. Search						
	_	urity were dispatched to					
	search for him around	•					
	stations. The DON wa	as notified. [Responsible					
		led, and she said [resident's					
	,	m bus stop around the					
	•	am converged around the					
		ntually we got a call fromthe					
		e police found resident at a					
		ing to the facility, resident					
	police officer. At this p	ing lot accompanied by the					
	•	r, it took about 40 to 45					
		and convince resident to					
		At 8:50am, [Resident's					
	name] returned to the	· -					
	encouragement. Resid						
		ot in acute distress. Head to					
		Denied pain, no discomfort					
	noted. Skin warm to a	nd dry. Respiration is even					
	and non-labored. Tem	perature 98.0, Pulse 62,					

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '				IPLETED
		095020	B. WING			0:	C 3/20/2024
	PROVIDER OR SUPPLIER	HOME		1818	EET ADDRESS, CITY, STATE, ZIP CODE S NEWTON ST. NW SHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Respirations 18, Bloo Saturations 96%. Wh from the facility, residuant to stay here and out again. New order one on one until seer Close monitoring in processing of the facility dated 04/04/23 lacked the following: -The staff findings whistorage, and equipmed kitchen areas, the base other furniture, beneat vehicles, shrubbery, puthe neighborhood, as Resident policy. - If neglect occurred, the neighborhood in Resident Abuse/Abuse - Interviews of Unit #1 who might have known Interview of ex-wife artheir Prohibition of Reprevention policy. It should be noted that elevator on Unit 1 to eshowed that facility st documented evidence investigation was contelled the investigation was contelled the investigation of the reviewed the revi	d Pressure 128/81, Oxygen en asked why he eloped lent stated that he does not verbalized that he will walk given to monitor resident by the psychiatricteam. Togress and maintained." It's investigation packet documented evidence of len they searched the boiler, ent rooms, laundry and sement, beneath beds and outlined in the Missing lot, bus stops, and outlined in the Missing let extent and cause of the lateir Prohibition of le Prevention policy. Is night shift staff (person ledge of the incident) and led daughter. As outlined in sident Abuse/Abuse It the resident got off the exit the front door. This laff failed to have that a thorough ducted for Resident #192's	F	610			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED
		095020	B. WING_			C 03/20/2024
	PROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP COD 1818 NEWTON ST. NW WASHINGTON, DC 20010	L DE	03/20/2024
(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 BE	(X5) COMPLETION DATE
	conducted by the faci stated that she looked investigative docume additional documents for Resident #192's ed. Cross reference 483 2. The facility staff fai investigation into Resident #294 was at 06/16/23 with multiple following: Hemiplegia Cerebral Infarction Aff. Side, Pressure Ulcer and Diabetes Mellitus Review of Resident #2 revealed the following: An Admission MDS as showed facility staff of Mental Status (BIMS) which indicates intact A Facility Reported Incumented: A Facility Reported Incumented: Resident's wife called husband's head was how care on the weekend ("Writer went to reside the charge nurse that we was a contact of the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a contact on the weekend ("Writer went to reside the charge nurse that we was a conta	dity. The employee also de through other facility and any related to the investigation lopement on 04/04/23. 25 Quality of Care F689 led to conduct a thorough ident #294's allegation of diagnoses that included the and Hemiparesis following fecting the Non-Dominant of Sacral Region Stage 2, Type 2. 294's medical record: sessment dated 06/21/23 oded: A Brief Interview for summary score of "15" cognition. cident (FRI) DC~12177 was Agency on 08/08/23 that de writer and stated that her it on the wall 3 times during	F 6	310		
	when I was being char	ad on the bed rail 3 times nged." When asked if he he stated, "she cameand				

1	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				4	С
		095020	B. WING		03/20/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW	
STODDA	RD BAPTIST NURSING H	OME		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)	
	gave me my medicati that she came into restroutine medications we face because he had resident nodded his he cleaned my eyes and When asked if he told about his head, he state to say that his aide for A review of the facility showed no document assessed the resident interviewed all the state alleged incident, or that residents. During a face-to-face in 03/18/24 at approximate (Director of Nursing) seleadership has change locate any additional of Resident #294's allegations. Cross Reference 22B 3. Facility staff failed to Resident #244's allegations.	ons." Charge nurse stated sident's room, to pass his which she did after wiping his some crusts on his eyes. ead and said "yes she gave me medications." charge nurse at that time ated "no". Resident went on that Sunday was a male." 's investigation packet, ed evidence that the facility in notified the physician, ff present at the time of the at they interviewed other Interview conducted on ately 3:30 PM, Employee #2 tated that the facility ed, and she was not able to documentation concerning ation of abuse. DCMR sec. 3269.1	F 61		
	11/08/21 with diagnose	admitted to the facility on es that included: Vascular ommunication Deficit, and nvolving Cognitive			

	F CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095020	B. WING				C
NAME OF B	DOWNER OF SUPPLIED	033020	D. W.10			0:	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	IOME		1	818 NEWTON ST. NW		
				V	VASHINGTON, 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)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
146	THE OBLITORY ON	EGG IDEIVIN TING INI GRAMATION)	IAG		DEFICIENCY)	A1L	
			-				
F 610	Continued From page	2.41	-/	240			
, 010	Continued From page	341		610			
	Daview of Davidant #	1001m mandinal annual					
	Review of Resident #	63's medical record					
	revealed:						
	A consus tracking for	m showed that Resident #63					
	resided on unit 1, roo						
	03/14/2023.	12 1, 7 bod, onloc					
	A Quarterly Minimum	Data Set (MDS)					
	assessment dated 04	/11/23 showed facility staff					
	coded: a Brief Intervie	ew for Mental Status (BIMS)					
	summary score of "09	9", indicating moderate					
	cognitive impairment;	no potential indicators of					
		oral symptoms directed at		1			
		nce for locomotion on the					
		tations in range of motion in					
	upper/lower extremitie						
		anxiety and antidepressant					
	mediations 7 times du	ining the last 7 days.					
İ	A Facility Reported In	cident (FRI), DC~12019,					
		Agency on 06/09/23 at 8:10					
	PM documented:	rigorioy on ocroorzo at o. 10					
		a at around 6:15 PM,					
		a verbal threat to shoot					
	another resident in Ro	om 102A [Resident #244]					
	with a gun, making an	attempt to reach for					
1	_	clothing. Immediately, the					
	staff called 911.						ŀ
		me at 6:30 PM and					
		3 and her belongings. No					
	guns or any related inj	s notified and referred to the					
	psychiatrist for review.						
	- Representative av						
		vise nursing staff to					
		and departed at 7:00 PM.					
	,	•					
	3B. Resident #244 was	s admitted to the facility on					

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY IPLETED
							С
		095020	B. WING			03	3/20/2024
NAME OF F	PROVIDER OR SUPPLIER			ł	STREET ADDRESS, CITY, STATE, ZIP CODE		***
STODDA	RD BAPTIST NURSING H	IOME		l	1818 NEWTON ST. NW		
				1	WASHINGTON, DC 20010		
(X4) ID		ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	. D		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 610	Continued From page	e 42	F	610			
	06/17/21 with diagnos	ses that included: Cognitive					
	Communication Defic						
	Impairment and Musc	le Weakness.					
	Paviou of the residen	t's medical record revealed					
	the following:	it's medical record revealed					
	are ronowing.						
	A census tracking for	n showed that Resident					
		1 room 102, A bed, since					1
	04/11/23.						
An Annual MDS assessment dated 04		ssment dated 04/12/23					
		oded: a BIMS summary					
	score of "15", indicatir						
	indicators of psychosi	s; no behavioral symptoms					
		rs; no functional limitations					
	in range of motion for						
	independent with walk	king and picking up objects.					
	A FRI, DC~12018, red	ceived by the State Agency					
	on 06/09/23 at 7:58 Pl						
		ed at the dinner area at					
	around 6:15 PM.						
	•	ported to the charge nurse					
		n room 124 A (Resident					
		will shoot her with a gun, ch for something under her					
	clothing.	or something under her				l	
	- Immediately, the	staff called 911.					
:		ne at 6:30 PM and					
	searched Resident #6	3's room and her					
1	belongings. No guns or	any related injurious					
	objects found.						
	• •	representative weremade					
	aware.Police officers adv	vise nursing staff to					
- 1		and departed at 7:00 PM.					
	•	•					
	Review of the investiga	ation documents provided					

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	ING		COMPLETED	
		095020	B. WING			C 03/20/2024	
	PROVIDER OR SUPPLIER RD BAPTIST NURSING	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE	
F 625 SS=D	to the surveyor on 03 #244 reported the ind (Assistant Director of review of the investig facility staff failed to divestigation as evide interviews or statemed persons (alleged vict and no interviews froutime of the alleged in During a face-to-face 10:35 AM, Employee finding and stated, "Veryong shift, I do the incident (DOH), collect residents and staff. A DON. I can't remembe anyone when this incomposed to the control of the second of the second of the second of the second of the second of the any, during which the return and resume restacility;	S/11/24 showed that Resident cident to Employee #3 If Nursing/ADON). Further gation documents showed conduct a thorough enced by no documented ents from the involved im and alleged perpetrator) in the staff present at the cident. In interview on 03/12/24 at #3 acknowledged the When there's an incident on dent report to Department of a statements from the III that gets forwarded to the er if I got statements from ident happened." B DCMR Sec. 3232.2 colicy Before/Upon Trinsfr (2) Colicy Before/Upon Trinsfr (2) Colicy Before transfer. Before a ers a resident to a hospital or therapeutic leave, the covide written information to not representative that State bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state	F6	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095020	B. WING				
NAME OF PROVIDER OR SUPPL	IFR	095020	B. WING	S	TREET ADDRESS. CITY. STATE. ZIP CODE	03/2	20/2024
STODDARD BAPTIST NUR		ОМЕ		1818 NEWTON ST. NW WASHINGTON, DC 20010			
PREFIX (EACH DE	EFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
bed-hold perio paragraph (e)(resident to retu (iv) The inform of this section. §483.15(d)(2) the time of tran hospitalization facility must president represent specifies the described in partial REQUIRE by: Based on reco one (1) of 41 stailed to provious with written information of the state be hospital. The findings in Review of the reviewed on 0 to 1. The admission Hold notification contact each ting. The form will day. The notificating bed-hold] day Resident #66 states and the review of the reviewed on other the states and the review of the reviewed on other the states and the reviewed on other the states and the reviewed on other the reviewed on other the states and the reviewed on other the reviewed on oth	g facility of the urn; and nation shall served and the urn aragraped and the urn aragraped facility of the urn; and urn aragraped facility of the urn aragra	y's policies regarding ch must be consistent with is section, permitting a dipecified in paragraph (e)(1) Ild notice upon transfer. At a resident for apeutic leave, a nursing to the resident and the re written notice which of the bed-hold policy of (d)(1) of this section. It is not met as evidenced ew and staff interviews, for a residents, facility staff dent #66's representative on that specified the duration policy before transfer to the se will mail out the "Bed" to each resident/point of y are out of the facility. Iled out the next business I provide the number of ining. mitted to the facility on ses that included: Dementia,	F	625	 The Admissions Director verbally notified spouse of resident #66 b days. Resident returned to his preson after hospitalization (3/5/24). Social Services Coordinator and medical records of residents sen hospital over past quarter (Janual March 2024) on 3/7/24 and found twelve 6-108s were not done. All completed by 4/1/24. Social Services Director will updated Hold Policy by 5/1/24. The Admissional Social Worker staff were reeducated by the Staff Developme Bed Hold Policy. Staff developme educate staff on changes by 5/14. The IDT will review all hospital trated that occurred within previous 24-24 hours during daily clinical meeting timely monitoring of policy complisities beginning 4/25/24. The Performance Improvement Expression of Wall report results of daily compliant reviews to QAPI Committee montant months beginning 5/14/24. Completion Date: 5/17/24. Title of person(s) responsible not POC. 	ed hold evious lited to ary-d were ate Bed sion, ant on ent will 1/24. Insfers 18 g for ance Director noce thly x 3	

	F CORRECTION	IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COMPLETED	
				-			С
		095020	B. WING			03	3/20/2024
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	OME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	Review of the Resider revealed the following. It was noted that the fresident #66's wife a emergency contact. A Significant Change assessment dated 12 staff coded: a Brief Int (BIMS) Summary Score severely impaired cognormal formula for the severely impaired cognormal formula for the severely impaired cognormal for the severely impaired cognormal formula for the severely impaired cognormal formula for the severely impaired cognormal formula for the severely impaired cognormal formula for the severely impaired cognormal formula for the severely impaired cognormal for the severely impaired cognormal formula for the severely impaired f	int #66's medical record is ace sheet documented is his responsible party and a Minimum Data Set (MDS) (19/23 showed that facility terview for Mental Status are of "03" indicating initive status. Background Assessment dated Sunday, 02/04/24 at iter was notified by charge iter was	F	625			
	During a face-to-face i	nterview on 03/07/24 at	_				

PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	IG		PLETED
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 625 Continued From page 46 9:29 AM, Employee #4 (Social Services Director) stated that the written notice of bed-hold policy and number of bed-hold days was done by Admissions Department. "I am not sure who does that (provide bed-hold policy/days) on the off hours or weekends." A face-to-face interview was conducted on 03/07/24 at 11:05 AM with Employee #12			095020	B WING			
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROM DEFICIENCY			B. WING_	1818 NEWTON ST. NW		3/20/2024	
9:29 AM, Employee #4 (Social Services Director) stated that the written notice of bed-hold policy and number of bed-hold days was done by Admissions Department. "I am not sure who does that (provide bed-hold policy/days) on the off hours or weekends." A face-to-face interview was conducted on 03/07/24 at 11:05 AM with Employee #12	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	3E	(X5) COMPLETION DATE
(Director Sales and Marketing). Employee #12 stated, "The process is to review and check the nurse's notes and physician's orders to see what residents were transferred out. The residentswho were transferred out are then discussed during stand down meeting (conducted on weekdays), at which time, a 6-108 [Notice of discharge, transfer, relocation] form is generated. I can't answer as to why Resident #66 does not have one for February [2024]. I was told that it was completed, but the ball was dropped on that one." Cross Reference 22B DCMR Sec. 3270.1 (Facility staff failed to discharge Resident #66 in accordance with the Nursing Home and Community Resident's Protection Act of 1985 (District of Columbia Law 6-108)). Grity Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	F 638	9:29 AM, Employee a stated that the writter and number of bed-h Admissions Department that (provide bed-hole hours or weekends." A face-to-face intervie 03/07/24 at 11:05 AM (Admissions Director) (Director Sales and M stated, "The process nurse's notes and phyresidents were transferred out a stand down meeting (which time, a 6-108 [M relocation] form is ger why Resident #66 down February [2024]. I was but the ball was dropped Cross Reference 22B (Facility staff failed to accordance with the M Community Resident (District of Columbia L Qrtly Assessment at L CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instruand approved by CMS once every 3 months.	#4 (Social Services Director) In notice of bed-hold policy old days was done by ent. "I am not sure who does Id policy/days) on the off ew was conducted on with Employee #12 In and Employee #13 Inrketing). Employee #12 In and Employee #13 Inrketing). Employee #12 In and Employee #13 Inrketing). Employee #12 In and Employee #13 Inrketing). Employee #12 In and Employee #13 Inrketing). Employee #12 In and Employee #13 Inrketing). Employee #12 In and Employee #13 Inrketing). Employee #13 Inrketing). Employee #14 In and Employee #15 In and Employee #16 In and Employee #17 In and Employee #18 In and Employee #19 In and Empl		25		

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		095020	B. WING _			03	/20/2024
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0.000				WASH	IINGTON, DC 20010		:
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F 638	Continued From page	e 47	F6	3 8 1	F 638 – Quarterly Assessments E	very	
	one (1) of 41 sampled	d residents, facility staff	'	t	three months.		
		juarterly (every 3 months)			1	4	
	assessment for Resid	dent #72.			 Sections of quarterly assessm were completed by social wor 		
					Resident #72, which included	KEI IUI	
	The findings included	:			language, ethnicity and race a	and	
	Review of the facility's	s contracts showed that			modification submitted. (3/4/24		
	•	ective on 02/12/24, was			•		
		eting the facility's Minimum		2	2. The DON reviewed MDS	İ	
	Data Set (MDS) assessments. The contract				transmittal sheet for January -		
	documented:				2024 to identify other residents potentially affected. All were	6	
		nall provide the facility with			completed. No other		
		nent support, specifically, to			residents were impacted by th	is	
	_	ode and confirm timely		}	practice. (4/18/24).		
		ssion, quarterly, annual and status MDS assessments.					
	significant change in s	status MDS assessifierits.] 3	3. The Performance Improvement		
	Resident #72 was adr	mitted to the facility on			Director educated all members	t t	
		ses that included: Pressure			Interdisciplinary team on timely completion of MDS assessment		
1		n, Stage 3, Dysphagia,			(4/17/24). The Performance	its	
	Aphasia, Pain, and Ce	erebral Infarction.			Improvement Director develop	ed	
					tracking tool to monitor timely		
		72's MDS transmittal sheet	1		completion of assessments.		
	provided to this survey	yor on 03/08/24			The Interdisciplinary team will	review	
	documented:				findings in clinical meetings daily. (4/25/24).		1
		ment - dated 10/03/23			11100tiligo dally. (4120124).		j
	showed "Accepted", in				4. Results of tracking tool will be		
	Services (CMS).	r Medicare and Medicaid			reported to the QAPI committe		
	- Quarterly MDS asse	ssment - with an			monthly x3 months and on-goi	- 1	. [
	•	e date (ARD) of 02/16/24			as necessary by the Director of	ot	
		indicating that it had not			Performance Improvement. (5/14/24).		
	been completed by fac				(0/14/24).		
	•			5	5. Completion date 5/17/24.		
		t this Quarterly assessment			·	1	-
		npleted within 14 calendar		6	6. Title of person(s) responsible	noted in	
	days of the ARD (03/0	11/24).			POC.		
	However, review of Se	ection Z (Assessment					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		095020	B. WING		03/20/2024
	ROVIDER OR SUPPLIER	IOME		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
SS=D	Administration) of the of 02/16/24 documen (Ethnicity), A1010 (Rawere not completed under the part of the ARD to complete sections of the assessing frame is consided date is February 16th signed on March 4th, yes, that is considered to the evidence showed complete a quarterly from the for Resident #Encoding/Transmitting CFR(s): 483.20(f)(1)-(\$483.20(f) (Automated requirement-\$483.20(f)(1) Encoding a facility must encode the each resident in the facility must encode the each resident change (iv) Quarterly review and (v) A subset of items under the part of the part	Quarterly MDS with an ARD ted: Sections A1005 ace), and A1110 (Language) antil 03/04/24 (3 days late). Perview on 03/14/24 at 12:36 Director of MDS Support tere is a 14-day window from all the information in all sment. Anything after that tred late. If the ARD end (2024] and the section is [2024], per the regulation, d late." If that facility staff failed to MDS assessment every 3 to 272. If Resident Assessments 4) If the ARD end (2024) and the section is [2014], per the regulation, d late." If that facility staff failed to MDS assessment every 3 to 272. If the ARD end (2024) and the section is [2014] and the section is [2015] and the section is [2015] and the section is [2015] and the section is [2016] and	F 640	 Section C of the MDS was comp for resident #89 on 3/4/24 by Social Worker and transmitted. The Director of Nursing reviewed transmittal sheets for past quarter (January - March 2024). All MDS were completed and acc No other residents were affected by this practice. (4/18/24). Staff development educated all the Interdisciplinary Team on timely completion of all MDS sections (4/17/24). Performance Improvem Director developed tracking tool to 	MOS epted. ne nent n thly x ement
	.,	•			

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG			PLETED
		095020	B. WING			C 03/20/2024	
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, 2 1818 NEWTON ST. NW WASHINGTON, DC 20010	ZIP CODE		
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F 640	a facility must be cap CMS System information contained in the MDS standard record layout and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility encoded, accurate, at the CMS System, incl. (i) Admission assessment. (ii) Annual assessment (iii) Significant correct (v) Significant correct (v) Significant correct (v) Significant correct (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (faccinitial transmission of does not have an adm. §483.20(f)(4) Data for transmit data in the fofor a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: Based on record review one (1) of 41 sampled failed to have docume Admission Minimum E Assessment was com.	able of transmitting to the tion for each resident in a format that conformsto ats and data dictionaries, dardized edits defined by ittal requirements. Within a completes a resident's must electronically transmit and complete MDS data to uding the following: ment. int. in status assessment. ion of prior full assessment. ion of priorquarterly upon a resident's transfer, and death. e-sheet) information, for an MDS data on resident that anission assessment. mat. The facility must remat specified by CMS or, an alternate RAI approved specified by the State and is not met as evidenced ew and staff interviews for residents, facility staff anted evidence a resident's	F	640			

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID PRETIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 640 Continued From page 50 The findings included: Resident #89 was admitted to the facility on 01/29/24 with multiple diagnoses that included: Cerebral Infarction and Multiple Sclerosis. Review of Resident #89's medical record revealed: An Annual MDS Assessment dated 02/05/24 documented: "Section C - Cognitive Patterns, Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be conducted? 1. Yes. However, there was no documented evidence that facility staff conducted the BIMS, as evidenced by Sections C0200, C0400 and C0500 were "blank". Additionally, there was no documented evidence of the resident's BIMS summary score that indicated the resident's Cognitive status. During a face-to-face interview conducted on 03/07/24 at 2:07 PM, Employee #4 (Director of Social Services) reviewed the Admission MDS	
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Social Services) reviewed the Admission MDS	
and stated that it was her role to complete section	
C (Cognitive Patterns) which she completes on	l
the day residents are admitted or the next day.	j
As of the date of this interview (38 days after	- 1
Resident #89's admission), facility staff had not	Í
completed the previously mentioned section of	ı
the Admission MDS.	
F 656 Develop/Implement Comprehensive Care Plan F 656	ı
SS=D CFR(s): 483.21(b)(1)(3)	
§483.21(b) Comprehensive Care Plans	-
§483.21(b)(1) The facility must develop and	
implement a comprehensive person-centered	
care plan for each resident, consistent with the	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095020	B. WING		C 03/20/2024	
	ROVIDER OR SUPPLIER	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	1 03/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 656	resident rights set for §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identifiassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, including treatment under §483.3 (iii) Any specialized screhabilitative services provide as a result of recommendations. If ifindings of the PASAF rationale in the reside (iv)In consultation with resident's representation (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was assessed local contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section. §483.21(b)(3) The section.	ch at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ed in the comprehensive aprehensive care plan must are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the ive(s)-als for admission and ference and potential for elities must document as desire to return to the seed and any referrals to and/or other appropriate	F 68	 F656 – Comprehensive Care in the care plan of resident #66 updated to include use of IVs and of cholecystostomy tube by Din Nursing. Resident #71's care pupdated to include falls. (3/7/2) The DON reviewed care plans for the period January - March ensure goals and approaches to meet residents' physical network addressed. No other residents affected by this deficient practice 4/18/24. DON and Performance Improon (PI) Directors reeducated IDT of the comprehensive assessment when developing care plans. IDT Team will review and upoplans during weekly Risk Man meetings beginning 5/2/24. The DON or designee will refindings to QAPI committee modes months. 5/14/24. Completion date: 5/17/24. Title of person(s) responsible POC. 	was and are rector of plan was 4). s 2024 to needed eds are were ce. vement on use nent date care agement port audit onthly x	

PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET) (X5) C 03/20/2024 STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET)		F CORRECTION	IDENTIFICATION NUMBER:	1		CONSTRUCTION	' '	PLETED
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PAGE REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010 PROVIDER'S PLAN OF CORRECTION (X5) COMPLET (EACH CORRECTIVE ACTION SHOULD BE COMPLET A			00.5000				l	
STODDARD BAPTIST NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE ONLY OF THE APPROPRIATE ONLY OF THE APPROPRIATE ONLY OF THE APPROPRIATE DATE	NAME OF PR	PROVIDER OR SUPPLIER	. 095020	D. WIING		TREET ADDRESS, CITY, STATE, ZIP CODE	03	720/2024
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	STODDAR	RD BAPTIST NURSING H	IOME					
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 656 Continued From page 52 care plan, must- (jii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 41 sampled residents, facility staff falled to develop a care plan with goals and approaches to address a residents' use of a central intravenous (IV) line and a cholecystectomy tube and falled to implement a resident's care plan intervention for falls. Resident #66 and Resident #71. The findings included: Review of the facility's "interdisciplinary Care Plans" policy, last reviewed on 1/1/10/22, it documented: - An individualized interdisciplinary care plan will be maintained for each resident Information recorded on the care plan includes date problems and/or needs first addressed, active problems and current needs of the resident. 1. Facility staff failed to develop care plans with goals and approaches for Resident #66's use of a central intravenous (IV) line and a cholecystectomy tube. Resident #66 was admitted to the facility on 12/27/21 with multiple diagnoses that included: Retention of Urine, Hypertension and Dementia. Review of the resident's medical record revealed the following: A Health Status Note dated 02/14/24 at 4:21 PM that documented:		care plan, must- (iii) Be culturally-compount of the resident with	petent and trauma-informed. It is not met as evidenced It wand staff interview, for a residents, facility staff re plan with goals and as a resident's use of a will line and a read failed to implement a ntervention for falls. Interdisciplinary Care it is "Interdisciplinary care plan each resident. Interdisciplinary care plan each resident. It is and/or needs first plems and current needs of the care plan with a for Resident #66's use of a will line and a mitted to the facility on diagnoses that included: prertension and Dementia. It's medical record revealed	F	356			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
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		095020	B. WING			03	/20/2024
	ROVIDER OR SUPPLIER	IOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	- Resident was readn to the facility Central line placed of upper arm Resident underwent placement on 02/04/2 - Right gallbladder dra Physician's orders da -Cholecystectomy tubupper), flush with 10 in Chloride two times a complete (milliliters) of saline experipherally inserted lumen brachial right, for monitor PICC line dreswelling and drainage line dressing every we every on Friday. Review of Resident #103/07/24, (22 days aft documented evidence a comprehensive resimith goals and approach a comprehensive resimith goals and approach a comprehensive resimith goals and approach goals are goals and approach g	chitted from [Hospitalname] on 02/09/24 on the right Cholecystostomy tube e4. dinage bag. ted 02/14/24 directed: be care (abdomen, right ml (milliliters) of 0.9 Sodium day; irrigate with 60 CC's very shift. central catheter (PICC), 1 for antibiotic treatment; ssing daily for redness, e every shift; change PICC eek, every evening shift 66's medical record on ter readmission) showed no e that facility staff developed dent-centered care plan aches to address the CC or the cholecystectomy lang. interview on 03/07/24 at 2 (Director of Nursing/DON) dings and stated, "Those lings and stated, "Those lings and stated on readmission of implement Resident #71's as for falls. cident (FRI), DC~11512,	F	656			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		PLETED
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		095020	B. WING			03	/20/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDA	RD BAPTIST NURSING H	HOME			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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	documented the followriter to room 321b to floor on her back with 5.10 am. When asked stated that two men of to upstairs. Resident intermittent confusion was done. A small cu head with minimal blecm (centimeters) and cleansed. Ice pack and Resident #71 was add 06/14/22, with multiple Parkinson's Disease, Deficit, and Personal Lymphomas. During an observation approximately 10:15 A (Licensed Practical Ninoted in her room lyin bed raised and bed in following was observed the wall behind the bereach. -The bedside table was bed with a thermos curesident's reach. -A floor mat was noted however, there was noted however, there was noted however, there was noted however, there was noted however, and the washeet. At the time of the Surveyor asked Resid press the call light for	wing: "Charge Nurse called to see Resident lying on the a pillow under her head at d what happened Resident carried her on the wheelchair is alert and responsive with the Head to toe assessment at noted on left side of the deeding. Area measured 0.1 no depth. Area was applied." mitted to the facility on the diagnoses that included: Cognitive Communication History of Non-Hodgkins and 03/04/24 at AM with Employee #7 urse/LN), Resident #71 was ag in bed with the head of a lowest position. The	F	656			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` `		PLE CONSTRUCTION		E SURVEY PLETED
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	ROVIDER OR SUPPLIER	IOME	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 PREF TAG	ĺΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	A review of Resident revealed the following A physician's order de "Floor mats (left and resident is in bed ever A Quarterly MDS ass showed that the facili Interview for Mental S score of "10" indicatir impairment; was total toileting, bathing and since the last MDS as A care plan dated 01/Area: Falls- [Resident 1/8/2024. Intervention monitor resident. Con the use of call light. E help when needed, C. Floor Mats at bedside safety q (every) shift." The evidence showed implement the followin #71's care plan: call limat at the bedside. During a face-to-face observation, Employe findings, placed the care	#71's medical record g: ated 01/17/23 directed, right) to bedside when ary shift for safety." essment dated 12/19/23 ty staff coded: a Brief Status (BIMS) summary ag moderate cognitive ly dependent on staff for dressing; and had 2 falls assessment. 09/24 documented, "Focus at #71] had an alleged fall on as included: Continue to tinue to educate resident on ancourage resident to call for all light within reach and a when resident is in bed for at that facility staff failed to ag interventions of Resident ght within reach and floor interview at the time of the e #7 acknowledged the all light and bedside table each, and placed the floor	F	65	6		
	Cross Reference 22B Treatment/Svcs to Pre CFR(s): 483.25(b)(1)(event/Heal Pressure Ulcer	F	686	5		

CENTER	3 FOR MEDICARE &	WEDICAID SERVICES				OIVID IVC	<u>7. 0930-039 i</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING _				C 20/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
					818 NEWTON ST. NW		
STODDAR	D BAPTIST NURSING H	OME			VASHINGTON, DC 20010		
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES					0.47)
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	Continued From page	e 56	F 6	886	F686 – Treatment/Prevention/Service Pressure Ulcers.	es of	
	0400 05(1) 01: 1 (.,			l 1. Resident #52's skin was assessed	1 and	
	§483.25(b) Skin Integ				her care plan reviewed to ensure a		
	§483.25(b)(1) Pressu				appropriate interventions were in p		
	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with				on 3/6/24.		
					Weekly skin Sweeps were initiated		
		ls of practice, to prevent			3/22/24 by the Director of Nursing for		
	•	loes not develop pressure			residents. No new skin issues were		
		vidual's clinical condition			for any resident. No additional resid		
		ey were unavoidable; and			were impacted by this deficient pra	ctice.	
		essure ulcers receives			3. The DON and Staff Development		
	with professional star	and services, consistent			educated the nursing staff on Pres	sure	
		ent infection and prevent			ulcers. DON to include additional re		
	new ulcers from deve				assessments (i.e., skin sweeps), ri	sk	
		is not met as evidenced			management processes and gener		
	by:	is not met as evidenced			interventions to prevent pressure u		
		iew and staff interviews, for			Staff Development Nurse to educa		
		d residents, facility staff			nursing staff on: Use of Braden so		
	, , ,	Resident #52 received care			skin Assessments, and Pressure U Documentation. DON and IDT will r		
		lcer development that was			pressure ulcer line listing weekly du		
	first observed at a Sta				RM meetings to monitor for any nev		
					pressure ulcers, the progress or	•	
	This deficiency result	ed in actual harm to			deterioration of existing PUs begin	ning	
	Resident #52 on 02/2	8/2024.			5/10/24.	· ·	
					4. DON or designee will report pressi	ıre	
	The findings included	:			ulcer outcomes noted in weekly RM		
					meetings to QAPI monthly x 12 mg	onths.	
		s Wound Care Consultant			(5/14/24)		
	Contract dated 09/14	· · · · · · · · · · · · · · · · · · ·			5. Completion Date 5/17/24.		
		ant agrees to serve as the			·		
		ant to coordinate medical			6. Title of person(s) responsible noted	ıın	
		d provide clinical guidance			POC.		
		ng wound care; provide					
		ent recommendations for					
	_	d date all orders, such as					
	medications."						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		E CONSTRUCTION		SURVEY PLETED
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		095020	B. WING	_		03	/20/2024
	ROVIDER OR SUPPLIER	IOME	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Review of the facility's Prevention and Care'documented: - Skin integrity alteration physician for treatmenter and the commenter of classification of prepartial thickness of skin is been lost, but derintact); may present an area of redness an full thickness of skin is subcutaneous tissues crater (unless covered black or yellow crust); also depth at this stage. A specific plan of carnursing and the interest of the "Reside Injuries" policy revised "Accurate assessmenter assessmenter assessmented as a professional will docur stage and pertinent of pressure injury on the in the medical record." Resident #52 was add 11/26/19 with diagnos Failure to Thrive, Histoweakness. Review of the resident the following:	s "Pressure Ulcers," policy revised on 11/10/22 fon will be reported to the ent orders. ssure ulcers: Stage 2: a cin is lost (epidermal layer emis is at least partially as blistering surrounded by d/or indurations. Stage 3; a s lost, exposing the stypesent as a shallow d by eschar - thick brown, emay be draining. There is ge. The must be developed by the disciplinary careteam. Lent Assessment - Pressure d on 11/10/22 documented, at addressing each will be conducted by rectly documented in the qualified health ment the presence, number, haracteristics of any wound documentation form.	F	686			

DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		FE SURVEY MPLETED
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NAME OF	200/40ED 00 014DD/450	095020	B. WING			03	3/20/2024
	PROVIDER OR SUPPLIER RD BAPTIST NURSING H	IOME		18	TREET ADDRESS, CITY, STATE, ZIP CODE 318 NEWTON ST. NW /ASHINGTON, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	emergency contact # Physician's orders da "Apply barrier cream" peri-area every shift f skin assessment, eve Friday; resident to ha every Monday and Th validate and ensure s completed." A Hospital Discharge documented: - Admission on 01/20/ - Chief complaint - alto oxygen and blood pre Physical exam at disc dry. A Readmission Note of documented: - Resident readmitted - Warm to touch skin, and in the inguinal are (intravenous) related to arm were noted. A Readmission Brader 01/27/24 documented: - Resident's score 11 Interpretation of scor - Continue current plant A care plan documented impaired skin integrity arm bruises/mass in the that was initiated on 07	ted 01/19/24 directed: to sacrum, buttocks and or skin protection; weekly rey evening shift every ve shower every day shift, nursday, Licensed nurse will kin assessment is Summary dated 01/27/24 24 at 1:57 PM. ered mental status,low ssure. charge - skin: warm and dated 01/27/24 at 9:01 PM into the facility. mass around themid-arm rea was noted, IV oruises on bilateral upper an Scale Evaluation dated e: 10-12 indicates high risk. an of care. ed: [Resident #52] has related to bilateral upper lie mid arm/inguinal area	F	686			

PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	F CORRECTION	IDENTIFICATION NUMBER:	1		E CONSTRUCTION		IE SURVEY MPLETED
		005000	B. WING			С	
NAME OF F	PROVIDER OR SUPPLIER	095020	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	0:	3/20/2024
	RD BAPTIST NURSING F	НОМЕ		1	NASHINGTON, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	11:21 PM documented no new skin issue no A quarterly Braden Searly identification of developing pressure 5:42 PM documented - Resident's score 11 10-12 indicates high resident's referrals necessare. Continue current plate A physician's order da "Turning and reposition tolerated and PRN (as A Significant Change (MDS) assessment da facility staff coded: a Status (BIMS) summa severe cognitive impate behaviors; required status assistance for toileting frequently incontinent risk for pressure ulcer unhealed pressure ulcother skin problems. A [nursing] Skin Obset Tuesday, 02/06/24, at "complete bed bath girnoted." A [nursing] Skin Obset Tuesday, 02/13/24, at "Complete bed bath girnoted."	ed, "complete bed bath given, ted." cale (a tool used to foster residents at risk for ulcers) dated 02/01/24 at l: (interpretation of score: risk). ary. an of care ated 02/02/24 directed, oning every 2 hours as so needed) everyshift". in Status Minimum Data Set ated 02/02/24 showed that Brief Interview for Mental ary score of "07" indicating airment; no rejection of care ubstantial/maximal go hygiene, shower/bathing; of bowel and bladder; at sylinjuries; and had no cers/injuries, wounds or rvation Tool Assessment on 8:20 PM documented, ven, no new skin issue rvation Tool Assessment on 10:53 PM documented, iven."	F	686			
		documented, "complete					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER	095020	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD		03/20/2024
NAME OF F	ROVIDER OR SUPPLIER			1818 NEWTON ST. NW	-	
STODDAI	RD BAPTIST NURSING F	IOME		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	
F 686	bed bath given, no new heat bath given, no new A [nursing] Skin Obset Friday, 02/23/24, at 1 "complete bed bath ginoted." A care plan focus are physical mobility r/t (right was initiated on 02/23 approaches/interventi "monitor/document/resymptoms) of immobi worsening, skin-break. The Treatment Admin February 2024 shower facility staff document initials to indicate that and that the nurse valishin assessment was. A Nursing Progress N PM documented: - Upon assessment, sitouch. - Resident turned and for comfort and pressure for bladder incontinent that was initiated on 0 approaches/interventic skin assessment."	ervation Tool Assessment on 0:37 PM documented, iven, no new skin issue a: The resident has limited elated to) weakness, that 3/24 had ons that included, port any s/sx (signs and lity: contractures forming or down." a: stration Record (TAR) for dot that on Monday, 02/26/24, ed a check mark and their Resident #52 had a shower idated and ensured that a completed. ote dated 02/26/24 at 2:24 kin is dry and warm to repositioned every 2 hours are relief. a: [Resident #52] is at risk ce related to deconditioning 2/26/24, that had ons that included, "weekly	F 6			
	An Attending Physicia 02/27/24, at 10:58 AM - Subjective: [Residentime in bed because states]	documented: t #52] spends most ofher				

4	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095020	B. WING				C /20/2024
	PROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE 1818 NEWTON ST. NW WASHINGTON, DC 20010	, ZIP CODE	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD B D TO THE APPROPRI CIENCY)	E	(X5) COMPLETION DATE
	There have been no care. - Objective: remains a female, in no acute dare no new labs avail. - Assessment: continclinically stable. We wan agement. A [nursing] Skin Or Tuesday, 02/27/24, a. Skin warm & dry, ski (WNL) and turgor is rigiven, no new skin iss. A Wound Care Physic 02/28/24, at 8:16 AM rounds: Stage 3 sacradrainage with necrotic clean with Dakins solutreat skin and tissue in collagenase Santyl (didead tissue) ointment. Although the Wound (a treatment order for fisacral ulcer, the medic documented evidence care physician was no new Stage 3 sacral pr 02/28/24. As a result, interventions were improved the color with Co	new issues regarding her a well-developed thin black istress when seen. There able foranalysis. ues to do well and remains vill continue with thecurrent The end of the end of	F	686			

	F CORRECTION	I (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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		095020	B. WING _			03/20/2024	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	re, zip code		
STODDA	RD BAPTIST NURSING H	IOME		1818 NEWTON ST. NW			
0.000				WASHINGTON, DC 20010			
(X4) ID	1	ATEMENT OF DEFICIENCIES	ID		LAN OF CORRECTION	(X5)	
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170	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		170	l .	FICIENCY)	3 (
F 686	Continued From page	e 62	F6	86			
	Review of the Februa	ry 2024 Treatment					
		d (TAR) dated from 02/01/24					
		nat facility staff documented					
		ir initials to indicate that					
	Resident #52:						
	1 Received a shower	everyday shift on Mondays					
		a licensed nurse validated					
	and ensured that the						١
	completed.						
	2. Received weekly sk	in assessments every					
	Friday on the evening						
	3. Barrier cream was	applied to the resident's			•		1
		peri-area every shift for					
	skin protection.						-
	A Upolth Status Note	dated 02/04/24 at 2:25 DM					
	documented:	dated 03/01/24 at 2:25 PM					-
		ert and verballyresponsive					
	with intermittent confu	• •					İ
	weakness.	3					
	- Upon assessment sk	in is dry and warm to					
	touch.						
		repositioned every 2 hours					
	for comfort and pressu	ire relief.					
	A [nursing] Skin Only I	Evaluation Note dated					
		ocumented, "Skin warm &					
		nd turgor is normal; no skin					
	issues; complete bed l						
	A nhysician's order da	ted 03/01/24 at 3:32 PM					1
		strength External Solution					
		chlorite) cleanse sacral					
		tion, pat dry, apply Santyl					
	and cover with border						

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3		TE SURVEY
	İ	095020	B. WING			C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW)3/20/2024
31000	NO BALTIST NONSINGT			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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	Continued From page	63	F 68	66		
	directed, "Santyl Exte	ated 03/01/24 at 3:38 PM rnal Ointment 250 Unit/GM al ulcer topically everyday				
	8:18 AM documented - Late Entry: created c - 100-year-old female	on 03/07/24 at 8:21 AM. with cachexia				
		•				
	A Skin Observation To 03/04/24 at 1:08 PM of Site: Sacrum Type: Pressure					
	- Length: 8 cm - Width: 6 cm	should be noted that wound				
	care physician staged as a Stage 3 on 02/28	the resident's sacral wound				
	Santyl. Cover with dry					
	documented:	dated 03/06/24 at 7:56 AM orly tolerated encouraged refused after several				
	 Resident on oxygen a for shortness of breath A call was placed to n to resident with poor in resident to the nearest 					,
	evaluation and treatme	ent.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG	(X:	3) DATE SURVEY COMPLETED
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		095020	B. WING _	V F1F = 11 / W V E V W V E V W V E V W V W V W V W V W V W W		03/20/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAI	RD BAPTIST NURSING H	OME		1818 NEWTON ST. NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	(X5) COMPLETION DATE
1740	NEODEN ON ON	DENTI THO IN ONWATION)	TAG	DEFICIENCY)	-KOFKIATE	
F 686	Continued From page	e 64	F6	.86		
	- A call was placed ar representative.	nd spoke with theresident's				
	documented:	dated 03/06/24 at 10:52 PM				
		ital name] at 10:30 PM to tus, resident has been				
	11:15 AM, Employee	interview on 03/06/24 at #2 (Director of "Skin assessments are				
	done weekly in PCC (
	form is used to assess	• ,				
	the process is to imme	ediately call the medical				
	progress note with a c	ders. The nurse will write a lescription of the wound that				
-	includes size, location surrounding area look	, drainage, what the s like and then also indicate				
	that the family was no either initiated or revis	tified. A new care plan is ed."				
	During a face-to-face i	interview on 03/13/24 at				
	Director/Resident #52'	's primary physician) stated, allowed to put in orders.				
		ides services at this facility				
		und Doctor] did not directly				
	resident (on 02/27/24)	. The nursing staff did not issues to me, and I did not				
		assessment of her skin				
	During a face-to-face in approximately 12:30 P	nterview on 03/20/24 at M, Employee #1				

LETED
20/2024
(X5) COMPLETION
DATE

PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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		095020	B. WING			03	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		İ
STODDA	RD BAPTIST NURSING H	IOME		1	1818 NEWTON ST. NW		
0,000,				V	NASHINGTON, 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)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
170	NEGOETTON ON		1	,	DEFICIENCY)		
1					F200 Face faces Accident/Ourses		
F 689	Continued From page	e 66	F	689	F689 – Free from Accident/Super	ison	
	Encephalopathy, Seiz	zures, Muscle Weakness			1. Resident #192 is no longer in fac	cility.	
	and Cirrhosis of the L				Unable to retrospectively correct.		
	Review of the medica	al record revealed the			DON completed Elopement Assessments on all residents. For	our	
	following:				residents were identified atrisk of	F	
					elopement. Pictures and face sh	ets	
	-	01/23 that documented,			were placed in Wanderer's Book maintained at concierge's desk,		
		192] has risk forElopement			(4/17/24).		
		evidenced by trying to enter					
	the elevator. Goal: Re	•		1	 Staff Development Nurse re-edual staff including security team of 		
	• •	sident's movements closely ourage resident to verbalize			elopement with emphasis on	л 1	
	feelings of boredom/lo	•			supervision 4/18/24. The admini	strator	
	Encourage resident to			1	initiated monthly meetings with security supervisor to review re-	ridont	<u> </u>
	activities of choice."	participate in group			behaviors to include wandering,	exit	
					seeking, and other behaviors re-	quiring	
	A Quarterly Minimum	Data Set (MDS)			monitoring and interventions by security team 4/22/24. DON and	IDT	
	assessment dated 02/	/12/23 documented the			review EHR clinical dashboard of		
	following: a Brief Inter-	view for Mental Status			monitor elopements and to valid	ate	
	, ,	e of "14", indicating the			supervision was provided per po and document 5/5/24.	licy	
	resident had an intact	-			and docament oroiza.		
		ent was coded for requiring			4. PI Director will report validation		
	supervision from staff	with activities of daily living .			from clinical dashboard to QAPI committee monthly x6 beginning		
	A Facility Reported Inc	cident Intake form			5/14/24.		
		by the State Agency that			E Completies Deta 5/47/04		
	was dated 04/04/23 at	10:59 AM documented the			5. Completion Date 5/17/24.		
		ed to: "At 6:55 am, resident			6. Title of person(s) responsible no	oted in	
		in his room. The security			POC.	100 111	
1	•	oms were searched. Code					ľ
		t) was initiated and 911 was					
	called at 7:20am and r						Ì
		o the police. A search team					1
	dispatched to search t	staff and security were					ļ
		tops and metro stations.		- }		į	1
		g a white sweat pants and					j
I	white hooded top long	•					
1		at the time is 58 degrees at				ŀ	[

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: J35811

Facility ID: STODDARD

If continuation sheet Page 67 of 112

095020 B. WING 03/20/202	
03/20/202	
	2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW	
STODDARD BAPTIST NURSING HOME WASHINGTON, DC 20010	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	(X5) DMPLETION DATE
F 689 Continued From page 67 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process." Please note, According to World Weather, the temperature in the District of Columbia on 04/04/23 during the daytime ranged from 55 to 75 degrees (Fahrenheit). https://world-weather.info/forecast/usa/washington_1/april-2023/ A nursing progress note dated 04/04/23 at 11:22 AM documented, "Resident was received in bed at 11:00 pm, alert, oriented and verbally responsive. During routine round, Resident was in bed through the night. Breathing even and unlabored. No sign of respiratory distress or shortness of breath noted. No complain of pain or discomfort volced. Around 5:30 am when I pushed my medication cart down the hall to start from room 218 where I normal start. Resident was in his room. When I got to his room at 6:40 am to give him his medication, I could not see him, I checked the bathroom, he was not there, then I alert other staffs and the supervisor, then called the security officer to found out if Resident left the facility. The staffs(sg) begin to search for him all rooms and bathrooms. I left the facility with other staffs in search of him tonearby bus-stops and metro stations." A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, "At 6.55 am, I was informed that the resident in room 2278 was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 91 was called at 7:20am and information about	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG			E SURVEY IPLETED
							С
		095020	B. WING _		3	03	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	VIII.		STREET ADDRESS, CITY, STATE, ZIP CODE		L	
CTODDA	TO DARTIOT MUROINO H	0.45		1818 NEWTON ST. NW			
STODDAI	RD BAPTIST NURSING H	ONE		WASHINGTON, DC 20010			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE			(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)			COMPLETION DATE
F 689	Continued From page	e 68	F 68	89			
	resident given. Searc	h team comprising of					
		urity were dispatched to					
	search for him around						
		as notified. [Responsible					
		led, and she said [resident's					
		m bus stop around the					
		am converged around the ntually we got a call fromthe					
		e police found resident at a					
		ing to the facility, resident					
		ing lot accompanied by the					
	police officer. At this p			·			
	coming into the facility	, it took about 40 to 45					
	minutes to encourage	and convince resident to					
		At 8:50am, [Resident's					
	name] returned to the						
	encouragement. Resid						
		ot in acute distress. Head to					
		Denied pain, no discomfort nd dry. Respiration is even					
		perature 98.0, Pulse 62,					
		d Pressure 128/81, Oxygen					
	-	en asked why he eloped					
		ent stated that he does not					
		verbalized that he will walk					
	out again. New order of	given to monitor resident					
	one on one until seen	by the psychiatricteam.					
	Close monitoring in pro	gress and maintained."					
	According to the inves	tigation packet, the					
	following employees w						
	04/04/23:?						
		documented, "I[employee's					
	name] worked last nigl						
		assigned to me. The last					
i i	_	name] was at 5:30 AM in					
		es on the night shift on unit d went to the street and					

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME STREET ADDRESS, CITY, STATE, 2P CODE 1918 NEWTON ST. NW WASHINGTON, DC 20010 (X04) D FREFIX TAG CACH DEPTICENCY NUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 69 metro station looking [for him] after he left the facility. We did not find him." Employee #15 (Housekeeping Director) documented, "I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiost) I walked thru the door (fell of the security desk) leading to the bird (cage) area and a resident waaring a white sweet suit and carrying a bag was coming off of Unit 1.1 asked where he was going, and he stated that his brother was picking him up front up front. He continued to the front desk area where security was sitting." Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an "incident Report" dated 04/04/23 that documented, "[Resident adaughter's name] called [Facility name] at 6:44 AM and confirmed (resident's name] was at the bus stop, I went to go look for [resident's name] as at the bus stop, I went to go look for [resident's name] as the bus stop and I returned to the nursing home at 7:20 AM." A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, "Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident seen secondary to elopement on 04/04/23 and review of 1:2 monitoring order. [Resident seen secondary to elopement on 04/04/23 and review of 1:2 monitoring order. [Resident seen secondary to elopement on 04/04/23 and review of 1:3 monitoring order. [Resident seen secondary to elopement on 04/04/23 and review of 1:3 monitoring order. [Resident seen secondary to elopement on 04/04/23 and review of 1:3 monitoring order in the fa		F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
MAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID REGULATORY OR ISC IDENTIFYING INFORMATION) FROM COMMENT STATEMENT OF DEPCICENCIES (EACH DEFICIENCY MIST BE REPECTED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) FROM COMMENT STATEMENT OF DEPCICENCIES (EACH DEFICIENCY MIST BE REPECTED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION) FROM COMMENT OR ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING IN ISC IDENTIFYING INFORMATION IN ISC IDENTIFYING INFORMATI						1
STODDARD BAPTIST NURSING HOME 1818 NEWTON ST. NW WASHINGTON, DC 2010			095020	B. WING		03/20/2024
(X4) ID (X4) ID (EACH DEPICIENCY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY AT TAGE CHARLES TAGE (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION). F 689 Continued From page 69 metro station looking [for him] after he left the facility. We did not find him." Employee #15 (Housekeeping Director) documented, "I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiosk)! I walked thru the door (left of the security desk) leading to the bird (cage) area and a resident wearing a white sweat suit and carrying a bag was coming off off unit 1. Lasked where he was going, and he stated that his brother was picking him up front up front. He continued to the front desk area where security was sitting." Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an "Incident Report" dated 40/40/423 that documented, "[Resident daughter's name] called [Facility name] at 6:44 AM and confirmed [resident's name] at the bus stop and I returned to the unrising home at 7:20 AM." A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, "Resident saced I have been here for too long; I was told at the other facility that I could leave." Remains on 1:1 monitoring, Alert and oriented to place, person, time, and situation. Does not present with any psychiatric disorder. Pleasant, not confused but appears to make poor and irrational judgement occasionally. Ambulates with steady gait. Continue 1:1 monitoring every shift for now and reassess for elopement risk in 4-5 days.	NAME OF P	ROVIDER OR SUPPLIER				
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 69 metro station looking (for him) after he left the facility. We did not find him." Employee #15 (Housekeeping Director) documented, "I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiosk) I walked thru the door (left of the security desk) leading to the bird (cage) area and a resident wearing a white sweat suit and carrying a bag was coming off of Unit 1.1 asked where he was going, and he stated that his brother was picking him up front up front. He confinued to the front desk area where security was sitting." Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an "incident Report" dated 04/04/23 that documented, "[Resident daughter's name] called [Facility name] at 6:44 AM and confirmed [resident's name] at the bus stop. I went to go look for [resident's name] at the bus stop and I returned to the nursing home at 7:20 AM." A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, "Resident seen secondary to elopement not 04/04/23 and review of 1:1 monitoring order. [Resident stated]"I have been here for too long; I was told at the other facility that I could leave. 'Remains on 1:1 monitoring. Alert and oriented to place, person, time, and situation. Does not present with any psychiatric disorder. Pleasant, not confused but appears to make poor and irrational judgement occasionally. Ambulates with steady galt. Continue 1:1 monitoring every shift for now and reassess for elopement isk in 4-5 days.	STODDAI	RD BAPTIST NURSING H	OME			
metro station looking [for him] after he left the facility. We did not find him." Employee #15 (Housekeeping Director) documented, "I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiosk) I walked thru the door (left of the security desk) leading to the bird (cage) area and a resident wearing a white sweat suit and carrying a bag was coming off of Unit 1. I asked where he was going, and he stated that his brother was picking him up front up front. He continued to the front desk area where security was sitting." Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an "Incident Report" dated 04/04/23 that documented, "[Resident daughter's name] called [Facility name] at 6:44 AM and confirmed [resident's name] was at the bus stop. I went to go look for [resident's name] at the bus stop and I returned to the nursing home at 7:20 AM." A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, "Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident stated] 'I have been here for too long; I was told at the other facility that I could leave. 'Remains on 1:1 monitoring. Alter and oriented to place, person, time, and situation. Does not present with any psychiatric disorder. Pleasant, not confused but appears to make poor and irretional judgement occasionally. Ambulates with steady gait. Continue 1:1 monitoring every shift for now and reassess for elopement risk in 4-5 days.	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
unit."		metro station looking facility. We did not fin Employee #15 (House documented, "I [emplouilding at 5:36 AM, a machine (kiosk) I wall security desk) leading a resident wearing a value bag was coming off was going, and he stapicking him up front ulteriot desk area where Continued review of the packet showed Employmote an "Incident Redocumented, "[Reside [Facility name] at 6:44 [resident's name] was go look for [resident's returned to the nursing A psychiatric nurse prod/05/23 at 6:58 PM of seen secondary to elo review of 1:1 monitoring have been here for too other facility that I coumonitoring. Alert and of time, and situation. Do psychiatric disorder. Pappears to make poor occasionally. Ambulate Continue 1:1 monitoring reassess for elopemer Encourage participation.	[for him] after he left the d him." ekeeping Director) oyee's name] entered the after signing in on the covid ked thru the door (left of the property to the bird (cage) area and white sweat suit and carrying of Unit 1. I asked where he afted that his brother was promoted from the continued to the esecurity was sitting." The facility's investigation by ee #16 (Security Guard) prort" dated 04/04/23 that ent daughter's name] called at the bus stop. I went to mame] at the bus stop and I grown at 7:20 AM." Cactitioner note dated documented that, "Resident spement on 04/04/23 and no order. [Resident stated] 'I be long; I was told at the lid leave.' Remains on 1:1 briented to place, person, we not present with any leasant, not confused but and irrational judgement es with steady gait. The gevery shift for now and and trisk in 4-5 days.	F 68	39	

PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			COMPLETED	
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		095020	B. WING			03	/20/2024
	PROVIDER OR SUPPLIER RD BAPTIST NURSING H	IOME		18	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	A State Survey Agend (DC~11872) dated 04 documented: It was on April 4, me at 7:00 AM stating home and was at a bit bus stop or where. I called the nursing my husband in the fact told me that he's at a what bus stop he was number. I called [Resident MPD (Metropolitan Pophone and stated that Cener train station (at the facility). The officer agree went and picked him took him back to the reallowing him to get out Review of Employees a personnel record show on 05/16/22. The empthe Training Checklist he received training of desk unattended." Mosigned an "Employee 04/12/23 that docume 04/03/23 between 5Al name] you [were] supposted at the front des [resident's name] from	cy Complaint Intake 4/10/23 at 3:30PM 2023 [Resident #192] called g that he's out of the nursing us stop and didn't know what Ing home asking them was cility, because he called and bus stop. They asked me is at and for his cell phone If #192] back, an officerfrom colice Department) got on the It they were at the Metro reproximately 3.1 miles from Ind to hold him. Mydaughter up from Metro Center and hursing home. In neglect on the staffthat's In he's on and security for It. If 16's (Security Guard) If 16's (Secu	F	689			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	COMPLETED
		005020	B. WING		C
	ROVIDER OR SUPPLIER	095020 OME	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	03/20/2024
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 689	On 03/08/24 at approobservation of the lob desk located adjacen. At the time of the obs and receptionist were the security desk, was security staff. Addition binder labeled "Wand (where security staff vand concerns in the fadesk. The security log evidence of Resident on 04/04/23. During a telephone in AM, Employee #17 (Nath Resident #192's informed her that staff resident (on 04/04/23) (Security Guard), who desk of the lobby, informed her that staff resident with other staff and Code Pink ar resident with other staff and the security defacility through the frostated that he was windesk unattended. He security guard to cover employee also stated report related to Reside the thought he wrote the security logbook.	ximately 11:00 AM, an oby area revealed a security to the facility's front door. ervation, a security guard seated at the desk. Behind is a closet that's used by hally, there was a three-ring ers" and a security logbook write notes about rounds acility) was noted on the gbook lacked documented #192's elopement incident terview on 03/13/24 at 8:30 dursing Supervisor) stated assigned nurse called and foculd not locate the lowas posted at the front formed her that he did not elocate out the front door, she and continued looking for the laft. Iterview on 03/13/24 at 9:30 decurity Guard) stated that walked into the closet lesk, the resident exited the look, the resident exited the look of reaving the front door. The employee long for leaving the front that he wrote an incident dent #192's elopement, and	F 68	39	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			С	
		095020	B. WING			03/20/2024	
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H SUMMARY ST	IOME ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010 PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
F 694 SS=D	approximately 10:00 approximately 10:00 Supervisor) stated the Guard) did not follow he left his post at from 04/04/23. He was to do in the building to covereviewed that logbood see documented Resident When asked if that indocumented in the logreplied "Yes". Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Parenteral fluids must with professional stan accordance with physicomprehensive person the resident's goals at This REQUIREMENT by: Based on observation interviews, for one (1) facility staff failed to for change Resident #66' central catheter (PICC Friday. The findings included: Review of the facility's (central venous access Change" policy dated - It is the policy of this	AM, Employee #18 (Security at Employee #16 (Security the company's policy when at desk unattended on call the other security guard er his post. Employee #18 k and stated that she did not dence that Employee #16 t #192's elopement incident. Cident should have been gbook, Employee #18 al Fluids. It be administered consistent adards of practice and incident orders, the in-centered care plan, and and preferences. Is not met as evidenced In, record review and staff of 41 sampled residents, ollow the physician's orderto is peripherally inserted C) line dressing every I "PICC/Midline/CVAD is device) Dressing 10/05/22, it documented: facility to change PICC, sing weekly or if soiled, in a		689	 The dressing was changed immediately by AD for resident #66 on 3/4/24. There were no additional residents with PICC lines. Nother residents were affected this practice. (3/3/24) DON will update Dressing Change policy by 5/13/24 to address inaccurate/incomple entries and requirement to for physician orders. Advanced Practice Nurse(s) will make weekly rounds on residents of IVs, ostomies, wounds begin 5/6/24, validate orders are implemented as prescribed a report findings to DON. Director of Nursing or design will use data compiled by Advanced Practice Nurses to monitor policy compliance. Report outcomes to QAPI monthly x 6 months. (5/14/24) Completion date: 5/17/24. Title of person(s) responsible noted in POC. 	o d by ete ollow with ning and nee	On-going

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	1 00/20/2024	
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F 694	and frequency of chareness and frequency of chareness and 12/27/21 with multiple Retention of Urine, Heview of Resident revealed: A Significant Change assessment dated 1 staff coded: a Brief II (BIMS) Summary So severely impaired con A Health Status Note that documented: Resident was read to the facility. Central line placed upper arm. Physician's order date of the PICC, 1 Lument the treatment, monitor Predness, swelling and Change PICC lievery evening shift, and Change PICC lievery evening shift, and on Friday, 03/01 monitoring the dress	will specify type of dressing ange. dmitted to the facility on le diagnoses that included: Hypertension and Dementia. #66's medical record #Minimum Data Set (MDS) 2/19/23 showed that facility interview for Mental Status fore of "03", indicating ognitive status. #dated 02/14/24 at 4:21 PM mitted from [Hospital name] on 02/09/24 on the right ted 02/14/24 directed, brachial right, for antibiotic ICC line dressing daily for d drainage every shift. The dressing every week, on Friday. ment Administration Record (2024 showed facility staff of the transport of	F 69			

NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	C 03/20/2024
STODDARD BAPTIST NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1818 NEWTON ST. NW WASHINGTON, DC 20010 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	00/20/2024
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
DETICIENCY)	(X5) COMPLETION DATE
F 694 With Employee #5 (Licensed Practical Nurse/LPN), Resident #66 was observed with a single lumen PICC to his right upper arm with a dressing that was dated, "2/9/24". When asked why the resident's central line dressing had not been changed since 02/09/24, the employee stated, "The dressing does not get changed on my shift (day shift, 7:00 AM - 3:30 PM) and only a Registered Nurse (RN) is allowed to change the dressing. I will get an RN to come and change the dressing. I will get an RN to come and change the dressing now." The evidence showed that from 02/14/24 to 03/04/24, facility staff failed to follow the physician's order to change Resident #66's central line dressing. It should be noted that the last documented central line dressing change was performed by hospital staff on 02/09/24. The first-time facility staff changed Resident #66's central line dressing was on 03/04/24 (24 days after the resident's readmission). During a face-to-face interview on 03/07/24 at 9:21 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated, "The physician's order was not followed and the nurses documented that they did something they in fact did not complete." Cross Reference 22B DCMR Sec. 3211.1 (Facility staff failed to ensure that sufficient time was given ensure that Resident #66's central line dressing was changed as ordered by the physician.)	
F 697 SS=G Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 697	provided to residents consistent with profe the comprehensive pand the residents' go This REQUIREMEN' by: Based on record revone (1) of 1 residents management, facility Resident #243 receiv assessments/evalua fracture. The findings included According to National Assessment of pair good pain management. Nurses working with must select the appreassessment for the consistent of the consistent it is done on a resifit, every 2 hours) assessment paramed directed. To meet the patient reassessed after each the effect and determine the effect and determine the effect and quality. Pain assessment so location, and quality. https://www.ncbi.nlm.	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan, als and preferences. T is not met as evidenced iew and staff interview, for a sampled for pain staff failed to ensure that are deffective pain ion for a known left hip. I Institute of Health (NIH): It is a critical step to providing ent. In patients with acute pain	F	697	 F697 - Pain Management Resident #243 no longer resides if facility. Unable to retrospectively opractice. The DON reviewed pain assessmall residents receiving routine and pain medication 4/22/24. Docume reflected pain management needs being met. No other resident is affiliby this practice. (4/22/4). DON and Staff Development to reeducate licensed staff on accuracy consistency in pain documentation characteristics, reconciling diagnotest results with physician orders, documentation, and order transcriting will include physician notificated diagnostic test results. Staff Development will also ensure licenstaff are trained on pain assessment documentation including assessment pre- and post- pain medication. (5 ADON to review resident docume for compliance for residents on analgesics in weekly RM meetings. ADON will report audit findings via audit of resident to QAPI Committed monthly x 12 months beginning 5/15. Completion date: 5/15/24. Title of person(s) responsible noted POC. 	ents for PRN ntation sare fected - y, n, pain stic ption. tion of ent ents /13/24). ntation s.	
	(not dated) showed:	ide optimal pain control,					

Facility ID: STODDARD

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F 697	residents with pain Pain will be measur Cognitively impaired utilizing behavioral or - Pain assessment w new pain. Review of the facility policy revised on 07/2 - Clinical notes for paseverity, quality, dura - Note when pain me important) and note it and length of relief. Resident #243 was a 05/15/19 with diagno Weakness, Other Ab Balance and Age-Re Review of the resident the following: A care plan focus are chronic pain to back a Osteoporosis, that we interventions that incomedications as order effectiveness; monitor of pain: location frequenction, alleviating famonitor and record a (guarding, withdrawa).	ed on a 0-10 scale. residents will be assessed residents will be assessed residents will be assessed residents will be assessed residents will be assessed residents will be assessed residents will be assessed residents will be assessed resident with the onset of s "Documentation Criteria" 22/22 showed: inin control include location, ation, and cause. dication is given (very f/when pain relief is obtained dmitted to the facility on ses that included: Muscle normalities of Gait and lated Physical Debility. nt's medical record revealed a: [Resident #243] has and knees related to as initiated on 05/16/19, had luded: administer ed. Monitor and record or and record any complaints uency, intensity, effect on actors, aggravating factors; ny non-verbal signs of pain l, crying, restlessness, etc.). ated 05/24/19 directed: "Turn	F	697			

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F 697	post fall, that was initi interventions of: admi and as needed, as or Evaluate/record/repore record any complaints intensity. Monitor and of pain (guarding, resand try to eliminate and try try try try to eliminate and try try try try try try try try try try	ain to right hip related to ated on 07/07/21, had nister medication routine dered. It effectiveness. Monitor and so of pain: location frequency, record any non-verbal signs tlessness). Handle gently my environmental stimuli. Intel 08/16/21 directed: Intel 08/16/21 directed: Intel 08/19/21 dire	F	697			

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F 697	"severe". A Facility Reported In received by the State PM documented: - At 4:40 PM, the resigive another resident step and fell on her leterate a	riew: verbal descriptor scale acident (FRI), DC~11996, Agency on 05/29/23 at 6:30 Ident got up on her seat to a hug and she missed her eft side. be assessed by the nurse she will be fine but in to the left thigh, 4/10. called and gave an order for ed leg. alled and was made aware of ated 05/29/23 directed "Left Note dated 05/30/23 at 6:50 Ithin normal limits bilateral rextremities with limited remity. rest but complained of uarding to left hip upon PRN Tylenol 00 mg with good effect. e done in the morning. dated 05/30/23 at 1:21 PM Itislocation or degenerative	F	697				

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F 697	femur without signit - Clinical Correlatio recommended as ir	of the neck of the proximal ficant displacement. In and follow-up imaging	F 69)7			
	PM documented: - X-ray for left hip/k received: No acute degenerative disea and vascular calcifi - Physician's Assist order given.	nee done this shift, results fracture, dislocation or se, there is a swelling tissue cation. ant (PA) made aware; no new					
	documented that sh	hat although Employee #7 ne received the results of the , she failed to inform the PA of					
	dated 05/30/23 sho	int of Care documentation wed that Resident #243 g minutes of walking on the - 3:30 PM).					
	PM documented: - Day 1 post fall	Note dated 05/30/23 at 11:37 pain to left hip/knee. Routine ministered as ordered.					
	showed that on 05/ 3;30 PM), facility st indicate that they w	ninistration Record (TAR) 30/23, day shift (7:00 AM - aff documented their initials to ere turning and repositioning by two hours. The TAR for the					

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F 697	section that directed shift", Employee #7 indicate that this tast there is no evidence such as intensity, pawere assessed ever known left hip fractu. The TAR also shows shift (3:00 PM - 11:3 documented their in were turning and rejevery two hours. The shift also showed the "monitor for pain ever documented their in was completed how that the pain charact pattern, frequency, as	also showed that in the l, "monitor for pain every documented her initials to k was completed however, that the pain characteristics attern, frequency, and duration in though the resident had a re.	F 6	97		
	Progress Note dated documented: - Range of motion was upper and right lower exposition of pain transparent of the proximal femur Received results of impression of non-deft proximal femur.	upon assessment. Given h good effect. No visible f left hip x-rays with isplaced fracture of neck of Clinical correlation and dicated. Morning shift to				

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F 697	F 697 Continued From page 81		F	697		
	It should be noted the documented that Research results showed a fractionary call the should be	at although the employee sident #243's left hip x-ray cture, he failed to notify the re physician.				
	facility staff document that they were turning #243 every two hours date and shift also state directed, "monitor for documented their init was completed howe that the pain charact pattern, frequency, a	at on 05/30/23, night shift, ated their initials to indicate g and repositioning Resident so. The TAR for the same nowed that in the section that a pain every shift", facility stafficials to indicate that this task ever, there is no evidence eristics such as intensity, and duration were assessed dent had a known left hip				
	05/31/23 at 8:47 AM, documented: - Status post fall, no - Resident guarding I complaints of pain to 50 mg and effective Result of left hip x-r of non-displaced fractemur. Clinical correl	Supervisor Note dated written by Employee #8 bruise, no redness noted. her left leg/hip. Medicated for left upper leg with Tramadol ways received with impression atture of neck of left proximal ation and follow-up imaging ow-up with primary medical				
	documented that Res results showed a frac resident's primary ca					
	dated 05/31/23 show	nt of Care documentation ared that Resident #243 minutes of walking on the				

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F 697	facility staff docume that they were turni #243 every two hou A Nursing Progress PM documented: - Status post fall, or follows: left hip/ Lef fracture. X-ray resurfracture of the neck without significant or [Physician's Name given to transfer remergency room for of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the left of the neck of the neck of the neck of the neck of the left of the neck of the	nat on 05/31/23, day shift, ented their initials to indicate ing and repositioning Resident iurs. S Note dated 05/31/23 at 12:22 order given on 5/29/23 as it knee x-ray to rule out all received and indicated "a cof the left proximal femur displacement." e] made aware, new order sident to the nearest or further evaluation of fracture eff proximal femur. O AM, resident left at 11:20 AM esentative made aware of ensfer. ge Summary dated 06/12/23 at ed: uted Tomography (CT) Scan of east: acute appearing mildly all left femoral neck fracture. ation of left femoral neck (the insertion of pins or wires hold the bones in a proper	F 6	97			
	03/12/24 at 12:20 F Practical Nurse/LPI day shift) stated, "T results are received	ce interview conducted on PM, Employee #7 (Licensed N who worked on 05/30/23, The process for when x-ray d is to call the medical doctor on't think I received both					

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F 697	else I would have do note." When asked results as documer 05/30/23 at 2:01 PM remember. I talked So, I don't believe to time." During a telephone AM, Employee #8 (worked on 05/30/23 no notification mador their representative result. The employee not have a physician to call of frames]. The employeen working here, not call the medical unless there's an erisk of dying. We worked not have a physician to call the medical unless there's an erisk of dying. We worked not salve as the sal	t #243] at the same time, or ocumented the results in my if she received both x-ray ited in her progress note on M, she replied, "I don't about the left knee, not both hat I had both results at the interview on 03/13/24 at 8:30 Night Shift Supervisor who so was asked why there was to Resident #243's physician in the regarding the left hip x-ray the stated that the facility did in son-call list [list of in specific days and time ye also said "Since I have the instruction has been to doctors during the night mergency and the patient is at ait until around 7:00-7:30 AM the doctors get angry when we	F 69	,		
	11:25 AM, Employee "There is no on-call providers at this face During off shifts (even are to contact the a if they can't reach ti If there's an abnorm makes sense to cal 3:00 AM. If there is incident, that should during that shift who	ce interview on 03/13/24 at the #6 (Medical Director) stated, schedule for the medical sility, but I am available 24/7. The sening and night), nursing staff sesigned medical provider and them, then they are to call methal result that is not critical, it I in the morning and not at an abnormal lab, x-ray, or all be reported to the provider that is not critical, it I in the morning and not at an abnormal lab, x-ray, or all be reported to the provider that is not critical.				

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F 761 SS=D	well-being should be not been reported to with reaching any of the evening or night. During a face-to-face 03/13/24 at 12:25 PN acknowledged the fir Label/Store Drugs ar CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biological labeled in accordanc professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In accordance Federal laws, the fact biologicals in locked temperature controls personnel to have acceptable storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when package drug distributions.	g that affects the resident's reported immediately. It has me that there are any issues the medical providers during shifts." e interview conducted on M, Employee #2 (DON) adings. In displaying and Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be ewith currently accepted is, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and illity must store all drugs and compartments under proper and permit only authorized in sees to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the	F 69	 F761 Label/Storage of Drugs and B Procurement Officer immediate oxygen tanks and relocated er basement. 3/4/24 Procurement Officer reviewed of oxygen tanks on both units were stored appropriately. 3/3/3 Staff Development will re-educ staff on Oxygen Safety and Staff/2/24. Nursing will notify Procupe officer when tanks are empty be removed from unit. Procure will also make daily rounds to tanks, remove them from the unit them in the basement storage pickup by the oxygen company. Procurement Officer will monit locations weekly. Report company QAPI Committee monthly x 3 response of the procurement of the procupe	the location to ensure all 24. The location to ensure all 24. The location to ensure all 24. The location to ensure all 24. The location to ensure all 24. The location to ensure all 24. The location to ensure and need to ensure to ensure all 24. The location to ensure a 15. The location to ensure a 15. The location to ensure a 15. The location to ensure a 15. The location to ensure a 15. The location to ensure a 15. The location to ensure a 15. The location to ensure a 15. The location to ensure all 24. The location to e	
	the Comprehensive I Control Act of 1976 a abuse, except when package drug distribution quantity stored is mir be readily detected.	Drug Abuse Prevention and and other drugs subject to the facility uses single unit		(5/14/24).		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING				20/2024
	ROVIDER OR SUPPLIER	ı		18	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010	1 03/	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 761	two (2) of two (2) oxy staff failed to ensure were not stored in the tanks intended for parameters and the stored in the tanks intended for parameters and the stored in the tanks intended for parameters and the stored for parameters and the stored for parameters and the stored for parameters and the stored for parameters and the stored for parameters and the stored for parameters and the stored for parameters and the stored for resid At the time of the obstated, "I'm not sure tanks in the supply responding to look and check the use for a patient (responding to the parameters and the basement for the basement in the basement for the basement in the basement in the basement in the supply responding to the parameters and the basement in the basement in the basement in the supply responding to the parameters and the parameters and the parameters and the parameters and the parameters are parameters and the parameters and the parameters and the parameters are parameters and the parameters and the parameters are parameters and the parameters and the parameters are parameters and the parameters and the parameters are parameters and the parameters and the parameters are parameters and the parameters and the parameters are parameters and the parameters a	ons and staff interviews, for igen storage rooms, facility that empty oxygen tanks e same area as full oxygen attient use. d: at Commission: Inders, as per the National ciation (NFPA) 99-2012, 11.6. Inders are different care use. fined as 'empty' by the segregated from all other ended for patient care use. mission.org/standards/stand environment-of-care-ec/0000 ing%20oxygen%20cylinders intended%20for%20patient% fon 03/05/24 at 10:09 AM of storage room, with insed Practical Nurse/LPN) on oxygen tank was stored in our (4) full oxygen tanks that ent use. servation, Employee #22 who checks the oxygen oom, but a nurse is supposed et tank before taking it out to ident), which means they it's empty. Empty tanks are	F	761			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	B) DATE SURVEY COMPLETED
		095020	B. WING _			C 03/20/2024
	ROVIDER OR SUPPLIER	OME	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			00/20/2024
(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761	#7 (LPN) showed two	storage room with Employee o (2) empty oxygen tanks	F 7	761		
	oxygen tanks. At the time of the obs stated, "Empty [oxyge downstairs. I would h (Director of Nursing) full oxygen tanks can remove the empty ox downstairs." During a face-to-face 03/05/24 at 10:56 AN acknowledged the fin facility did not have a storage of oxygen tar whoever checks the othat there are only full room."	me area with three (3) full fervation, Employee #7 en] tanks are stored ave to refer you to my DON about whether empty and be stored together. I will ygen tanks and bring them interview conducted on I, Employee #2 (DON) dings and stated, "The policy or procedure for nks. Best practice is for code carts to also ensure I tanks in the oxygen storage				
F 777 SS=D	safe storage of equip oxygen.) Radiology/Diag Srvcs CFR(s): 483.50(b)(2) §483.50(b)(2) The fac (i) Provide or obtain r diagnostic services o physician; physician a or clinical nurse spec State law, including s (ii) Promptly notify the physician assistant, r	cility must- adiology and other nly when ordered by a assistant; nurse practitioner ialist in accordance with cope of practice laws.	F 7	777		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING			20/2024
	ROVIDER OR SUPPLIER	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		20/2027
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 777	REGULATORY OR LSC IDENTIFYING INFORMATION)		I	 F777 Radiology/Diagnosis/Notife Resident #243 no longer reactions pective correction not for this resident. DON reviewed x-ray report residents on 3/25/24. Chart residents did not indicate pubeen notified. The physician on 3/25/24 of x-ray results worders given. DON to review clinical dash monitor changes in residen require physician notification radiology reports and lab rebeginning 3/27/24. Staff Deeducate licensed staff on rephysician for changes in contadiology/lab results outside reference range. (5/3/24) Pumprovement Director will in documentation daily during interdisciplinary meeting to notifications occur per policios/5/24. 	esides in facility. It implemented s for all It for 2 of 5 hysician had In was notified with no new hboard daily to It condition that It on such as esults evelopment to otification of ondition, or e of clinical reformance monitor resident clinical validate	
A Facility Reported Incident (FRI), DC~11996, received by the State Agency on 05/29/23 at 6:30 PM documented: - At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RP was called and was made aware of the fall accident. A Nursing Progress Note dated 05/29/23 at 7:36 PM documented:			 4. Performance Improvement report validation data as no meeting to QAPI committee (5/15/24) 5. Completion date: 5/17/24. 6. Title of person(s) responsib POC. 	oted in clinical e monthly x 6.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED		
			71. 501251	_		(
		095020	B. WING			03/	20/2024
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	ОМЕ		18	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 777	give another resident step and fell on her let - The physician was for an x-ray of the affer - Resident RP was aware of the fall accid. A physician's order da hip/left knee x-ray. Left knee x-ray results documented: - No acute fracture disease. Left hip x-ray results of documented: - There is a fracture femur without signification of the commended as individual as individual as individual as a commended as a commended as a commend	resident got up on her seat to a hug and she missed her off side. as called and gave an order ected leg. s called and was made dent. ated 05/29/23 directed, Left ated 05/30/23 at 1:21 PM a, dislocation or degenerative dated 05/30/23 at 1:21 PM re of the neck of the proximal ant displacement. on and follow-up imaging icated. lote dated 05/30/23 at 2:01 yee #7 (Licensed Practical inted: //knee done this shift, results acture, dislocation, or stant (PA) made aware; no at although Employee #7 received the results of the she failed to inform the PA of	F	7777			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		095020	B. WING _			C 03/20/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		03/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 777	impression of non-di- left proximal femur. (I follow-up imaging incomplete in the proximal femur. (I follow-up imaging incomplete in the proximal femur. (I follow-up imaging incomplete in the proximal femur. (I follow-up imaging incomplete in the proximal femur. (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follow-up imaging incomprimary medical doctor) A Day Shift Nursing (I follo	s of left hip x-rays with splaced fracture of neck of Clinical correlation and dicated. Morning shift (day PM) to follow-up with primary Supervisor Note dated written by Employee #8 Supervisor) documented: x-rays received with splaced fracture of neck of Clinical correlation and dicated. Please follow-up with tor. Progress Note dated M documented: order given on 05/29/23 as nee x-ray to rule out fracture. and indicated a fracture of roximal femur without tent. me] made aware, new order dent to the nearest further evaluation. 40 AM, resident left at 11:20 presentative made aware sfer. d that facility staff received hip and left knee x-ray at 1:20 PM, during the day PM). There is no see that the assigned day shift	F 7	77		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	l		1	TREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010	1 03/	20/2024
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 777	Continued From page	e 90	F	777			
	assigned night shift in both documented that x-ray showed a fracture resident's physician of the was not until 05/31/AM, 21 hours later, the Resident #243's prim RP of the left hip x-ray of the left hip x-ray During a face-to-face 03/12/24 at 12:20 PM Practical Nurse/LPN) when x-ray results ar medical doctor with the received both x-rher progress note on replied, "I don't remer knee, not both. So, I results at the time." During a telephone in AM, Employee #8 (Ni Supervisor) was asked notification made to Fitheir representative result. The employee on-call list. Since I had instruction has been adoctors during the nigemergency and the powait until around 7:00 the doctors get angry middle of the night."	/23, at approximately 10:30 nat facility staff notified ary care physician and their ary results. Interview conducted on M. Employee #7 (Licensed stated, "The process for e received is to call the ne results. When asked if ray results as documented in 05/30/23 at 2:01 PM, she mber. I talked about the left don't believe that I had both Atterview on 03/13/24 at 8:30 ight Shift Nursing ed why there was no Resident #243's physician or egarding the left hip x-ray estated, "We don't have an ave been working here, the to not call the medical					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			7 t. BOILD!					
		095020	B. WING _			03/:	20/2024	
	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	ОМЕ		18	TREET ADDRESS, CITY, STATE, ZIP CODE B18 NEWTON ST. NW /ASHINGTON, DC 20010			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 777	providers at this facility During off shifts (ever are to contact the assif they can't reach the An x-ray result that conshould not wait until many reported immediately resident's well-being simmediately. It has not there are any issues a medical providers during a face-to-face 03/13/24 at 12:25 PM Nursing) acknowledge comment. Food Procurement, St CFR(s): 483.60(i)(1)(2)(3)(4)(4)(4)(4)(5)(4)(5)(4)(5)(4)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	chedule for the medical ty, but I am available 24/7. Ining and night), nursing staff signed medical provider and m, then they are to call me. In owners back with a fracture, norning, that should be a Anything that affects the should be reported to been reported to me that with reaching any of the ring the evening or night interview conducted on the findings and made no core/Prepare/Serve-Sanitary (2). The food from sources are distincted as a stisfactory by federal, the sanitary subject to applicable State allations. The sanitary of the revenue of the provided that the sanitary is a soft prohibit or prevent roduce grown in facility ompliance with applicable		812				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING _			03/	20/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2024
				18	B18 NEWTON ST. NW		
STODDAF	RD BAPTIST NURSING I	HOME		W	ASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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)	TE	(X5) COMPLETION DATE
					F 812 Food Procurement/Storage/ Prepa	aration	
F 812	standards for food so This REQUIREMEN by: Based on observation staff failed to serve food failed to serve food failed to serve food failed to serve food failed failed to serve food failed failed to serve food failed fai	ance with professional ervice safety. T is not met as evidenced ons and staff interview, facility cods under sanitary ced by hot foods ere below 135 degrees (6) of six (6) observations, nevection ovens, and two (2)	F 8	3312	 During the survey, areas that could addressed immediately are reflected actions below: a. Test trays were used for pure of staff education as pertain hot food temperatures. Staff also re-educated on ensuring could be re-heated on the understand residents if requested. b. 2 of 2 convection ovens were cleaned immediately c. 2 of 2 grease fryers were cleaned immediately d. Open bags of RTE food item labeled to indicate "use by" being thawed improperly indicated could cuts, shredded cheese cheese, feta cheese, apple and frozen chicken were distimmediately 3/4/24. Manager checked all food items for labeling dates and packaging. Seve items were discarded. 3/4/24. Director reviewed and re-educated staff on foliabeling 3/7/24. 	rposes is to f were ng food nit for re eaned ms not date or cluding , sliced sauce, scarded proper ral or	
	puree hot foods such (104.1), potatoes (10 such as fried chicker and potatoes (106.6 degrees.	ratures were inadequate as a as chicken (106.5), spinach (05.8), and regular hot foods an (134.4), spinach (114.4), tested at less than 135			3. Production Manager conducted daily rounds to walk-in coolers, freezers, in coolers, and dry storage for food labeling/dating. 4/1/24. Evening Cooled update nightly Close Out Log to che labels/dates with new items added that as needed. 5/1/24. Production Manageview/update Master Cleaning Schof for daily, weekly, and as needed equipment cleaning by 5/5/24. Back supply of water sanitizer solution to maintained in Director's office to ensavailability 5/1/24.	reach- ok to eck for to Log ager to edule k-up be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			03	3/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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 812	fryers, were soiled wi Ready-to-eat foods so open packs of cold colors bag of shredded yello (5) open packs of slict one (1) open bag of foone (1) open jar of ap	th cooked food residue. uch as two (2) of two (2) uts, one (1) of two (2) open w cheese, three (3) of five ed yellow cheese, one (1) of eta cheese, and one (1) of oplesauce stored in the ere not labeled to indicate a	F	812	F 812 Food Procurement/ Storage/ Preparation. 4. Director will document audit finding from logs and report to QAPI Commi monthly x3 months 5/14/24. 5. Completion date: 5/17/24. 6. Title of person(s) responsible note POC.	ttee	
	_	chicken meat were full of water for thawing, with vater velocity to create					
	parts per million (PPN approximately 10:30 a	nk tested at less than 100 //) on March 4, 2024, at					
F 836 SS=D	Employee #9 during a March 11, 2024, at ap License/Comply w/ Fo	vere acknowledged by a face-to-face interview on oproximately 3:30 PM. ed/State/Locl Law/Prof Std	F	836			

T ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		095020	B. WING _			03/	20/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STODDAR	D BAPTIST NURSING H	OME		18	818 NEWTON ST. NW		
STODDAK	D BAPTIST NUKSING I	OME		V	ASHINGTON, 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
F 836	Continued From page	94	F8	36	F836 License Compliance		
	§483.70(a) Licensure A facility must be licer and local law. §483.70(b) Compliance			 The Chief Human Resources Officanceled the services of staffing a immediately. No additional service were provided by the staffing age (3/4/24). 	agency es		
	Local Laws and Profe The facility must oper compliance with all ap local laws, regulations accepted professiona that apply to profession such a facility. §483.70(c) Relationsh Regulations. In addition to complia forth in this subpart, fa the applicable provision regulations, including pertaining to nondiscr race, color, or nationa nondiscrimination on CFR part 84); nondisc age (45 CFR part 91) basis of race, color, n disability (45 CFR part subjects of research (and abuse (42 CFR p individually identifiable CFR parts 160 and 16 provisions may result non-compliance with	ate and provide services in oplicable Federal, State, and so, and codes, and with a standards and principles on als providing services in only to Other HHS Ince with the regulations set acilities are obliged to meet ons of other HHS but not limited to those imination on the basis of all origin (45 CFR part 80); the basis of disability (45 crimination on the basis of actional origin, sex, age, or the sext of th			 No other deficient practice was id as the facility has no other agency contract. (3/4/24). Human Resources will fully vet st agencies prior to entering into a contractual agreement to ensure requirements are met under state (i.e., at minimum to include busing license in DC and current insuran (3/4/24). Human Resources will monitor lice requirements and report to QAPI committee x 1 months and on-goi until compliance updated wheneves taffing agency is solicited. (5/14/5). Completion date 5/17/24. Title of person(s) responsible note POC. 	affing law ess ce). ense ng er 24).	
	Based on record revi facility staff failed to p	se Staffing Agency used to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095020	B. WING		03/20/2024	
	PROVIDER OR SUPPLIER	IOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		1 33/25/252-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 836	operating in compliar State, and local laws evidenced by providin Columbia (D.C.) on a The facility's census was 90. The findings included A review of a letter at Agency's Name] date Department of Health your Certificate of Lic period April 2, 2021, A review of the Staffin issued by the District license number with a 04/11/2022. A review of the Servic Staffing Agency and 02/02/23 by Employer Resources Officer) dichoosing [Nurse Staffing Agency and 102/02/23 by Employer Resources Officer) dichoosing [Nurse Staffing Agency revealed that staff (RN's, LPN's an 03/10/24, a combined shifts. During a face-to-face 03/18/24 at 1:04 PM reviewed the Nurse Staffing Rounds and shifts.	and regulations, as and services in the District of an expired business license. On the first day of the survey d: ddressed to [Nurse Staffing and 04/26/2021 from the D.C. and documented, "Enclosed is been sure that covers the through April 11, 2022." and Agency's business license of Columbia revealed a can expiration date of the facility, signed on the efficiency is not an expiration of the signed on the facility, signed on the efficiency is Name] to the facility used 14 nursing d CNA's) from 02/02/23 to dictotal of approximately 150 einterview conducted on Employee #2 (DON) Staffing Agency's expired stated, "I didn't know their	F 83	6		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		095020	B. WING			03/	20/2024
	ROVIDER OR SUPPLIER	ОМЕ		18	TREET ADDRESS, CITY, STATE, ZIP CODE B18 NEWTON ST. NW /ASHINGTON, DC 20010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 836	03/18/24 at 1:21 PM Human Resources Of the relationship betwee Name] and the facility RN's February 2023.' stated that she didn't Staffing Agency's lice Surveyors entered the Nurse Staffing Agency practice in D.C.	interview conducted on Employee #19 (Chief fficer) stated that, "I initiated een [Nurse Staffing Agency's a started using CNA's and The employee further ask about the Nurse until the State e facility on 03/04/24. If the nursing staff from the y all had current licenses to DCMR Sec. 3212.4		836			
SS=D	Cross Reference 22B DCMR Sec. 3212.4 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized						

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CENTER	3 FOR WEDICARE &	WIEDICAID SERVICES				OIVID NO	. 0930-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING			03/2	20/2024	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1:	818 NEWTON ST. NW			
STODDAF	RD BAPTIST NURSING H	OME						
					VASHINGTON, DC 20010			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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	
					F842: Medical Records			
F 842	§483.70(i)(2) The facall information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, paroperations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research permedical examiners, for a serious threat to he by and in compliance §483.70(i)(3) The face record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 years legal age under State §483.70(i)(5) The mere (i) Sufficient informatic (ii) A record of the research when the content of the research when the content of the research when the content of the research when the content of the research when the content of the research when the content of the content of the research when the content of	ility must keep confidential ned in the resident's records, nor storage method of the release isor their resident permitted by applicable law; yment, or health care ted by and in compliance; activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. Ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches	F	842	 Residents #66, 52, and 72 no long in facility. Unable to retrospectively DON completed audits of current retro. TARs for PICC line dressings and residents with pressure ulcers. No additional residents had PICC lines residents had pressure ulcers with noted. Assessments with corrected were completed 4/22/24. Audit was conducted by DON of monthly surrompleted in last 30 days. No inact were identified. 4/19/24. DON re-educated nursing staff on ulcers including routine assessments skin sweeps), risk management progeneral interventions to prevent progeneral interventions to prevent progeneral interventions to prevent progeneral interventions to prevent progeneral interventions and accuracy TARs. Staff Development to re-edulicensed nurses by 5/14/24 on skin assessments, pressure ulcer documentation and dressing change Performance Improvement Directo complete monthly nursing docume audits for accuracy and completents/13/24. Results of documentation audits we presented by Performance Improved Director to QAPI Committee monthmonths and ongoing as necessary 5/14/24. Completion date: 5/17/24. 	esidents' current s. Two no stage d staging is nmaries curacies pressure nts (e.g., ocesses, essure on of ucate ges. r will ntation ess by ill be ement nly x6		
	provided;	preadmission screening			6. Title of person(s) responsible noted	d in POC.		

Facility ID: STODDARD

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	, ,	COMPLETED			
		095020	B. WING _			C 03/20/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		, 00/20/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 842	professional's progre (vi) Laboratory, radio services reports as n This REQUIREMEN' by: Based on record rev three (3) of 41 samp	ucted by the State; e's, and other licensed ess notes; and elogy and other diagnostic equired under §483.50. T is not met as evidenced views and staff interviews, for led residents, facility staff ocument in the residents' dent #66,	F 8	42				
	reviewed on 07/22/2 The objective is on each resident in a professional standar complete, accurately accessible and system of the complete of	to maintain clinical records accordance with accepted ds and practices that are a documented, readily ematically organized. ed to accurately document nument Administration Record dmitted to the facility on e diagnoses that included: Hypertension and Dementia.						
	assessment dated 12 staff coded: a Brief I	Minimum Data Set (MDS) 2/19/23 showed that facility nterview for Mental Status ore of "03", indicating gnitive status.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		095020	B. WING		C 03/20/2024		
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	1 00/20/202		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	Continued From page 99		F 84	2			
	that documented: - Resident was readr to the facility Central line placed upper arm.	e dated 02/14/24 at 4:21 PM mitted from [Hospital name] on 02/09/24 on the right sed 02/14/24 directed,					
	- PICC, 1 Lumen treatment, monitor P redness, swelling an	brachial right, for antibiotic ICC line dressing daily for d drainage every shift. ne dressing every week,					
	(TAR) for February 2 documented a check indicate that the cent completed on Friday	nent Administration Record 024 showed facility staff mark and their initials to ral line dressing change was , 02/16/24, Friday, 02/23/24 /24 and that they were ing site every shift.					
	with Employee #5 (LI Nurse/LPN), Resider single lumen PICC to dressing that was da why the resident's cebeen changed since stated, "The dressing my shift (day shift, 7: Registered Nurse (R	n on 03/04/24 at 10:30 AM icensed Practical at #66 was observed with a b his right upper arm with a sted, "2/9/24". When asked entral line dressing had not 02/09/24, the employee g does not get changed on 00 AM - 3:30 PM) and only a N) is allowed to change the RN to come and change the					
		d that from 02/14/24 to f failed to failed to accurately nt #66's TAR.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING			C 03/20/2024	
	ROVIDER OR SUPPLIER	HOME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010	1 03/	20/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
F 842	9:21 AM, Employee a acknowledged the fir physician's order was documented that the did not complete." 2. Facility staff failed stage of Resident #50 ulcer/wound on the coplan. Resident #52 was act 11/26/19 with diagnor Failure to Thrive, His Weakness. Review of the resident the following: A Significant Change (MDS) assessment of facility staff coded: a Status (BIMS) summ severe cognitive impounhealed pressure ulother skin problems. A Wound Care Physical 8:16 AM documents	e interview on 03/07/24 at #2 (Director of Nursing/DON) ading and stated, "The sonot followed and the nurses y did something they in fact and to accurately document the 2's sacral pressure comprehensive resident care and the facility on ses that included: Adult attory of Falling, and Muscle are set atted 02/02/24 showed that Brief Interview for Mental ary score of "07" indicating airment and had no licers/injuries, wounds, or cian's Note dated 02/28/24 ted: "Wound rounds; Stage 3	F	842			
	necrotic tissue and s Dakins solution (used and tissue infections ointment (debrideme tissue) and dry dress	er; moderate drainage with lough; Plan: clean with d to prevent and treat skin), apply collagenase Santyl nt ointment used on dead ing daily."					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095020	B. WING		03/20/2024
	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 842	slough and drainage 6 cm wide by 2 cm of 6 cm of	d: decubitus ulcer. Decreased a. 8 cm (centimeters) long by leep. ea initiated on 03/05/24 dent #52] has sacral ulcer e interview on 03/06/24 at a #2 (Director of owledged the findings and ent's care plan would be B DCMR Sec. 3231.12 o accurately document the 52's sacral pressure ulcer on care plan.) ed to accurately document in ember 2023 monthly dmitted to the facility on oses that included: Pressure on, Stage 3, Dysphagia,	F 842		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '			(X3) DATE SURVEY COMPLETED	
	095020	B. WING _			C 03/20/2024	
ROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010	I	03/20/2024	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
A Nursing Progress NPM documented: Resident G tube The Physician's new order given to transcribe emergency re A call was placed ambulance and the re [Hospital name] via standard emergency re A Nursing Progress NAM documented: Resident returne [Hospital name]. New G-tube note no bleeding noted. A Resident Monthly S 12/30/23 at 4:45 AM New G-tube note no bleeding noted. A Resident Monthly S 12/30/23 at 4:45 AM New G-tube note no bleeding noted. This evidence showe inaccurately document on ER visits for the median During a face-to-face 12:46 PM, Employee acknowledged the fine Cross Reference 22E (Facility staff failed to course of treatment in summary report for Delifection Prevention 8	was dislodged. Assistant (PA) made aware, ansfer resident to the com for G-tube replacement. It call to non-emergency esident was transferred to tretcher. Idote dated 12/25/23 at 4:18 Id to unit at 5:10 PM from the documented: a dislocumented:					
CFR(s): 483.80(a)(1)	(2)(4)(e)(f)					
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC' REGULATORY OR L Continued From page A Nursing Progress N PM documented: - Resident G tube - The Physician's new order given to transparent emergency ro - A call was placed ambulance and the re [Hospital name] via st A Nursing Progress N AM documented: - Resident returne [Hospital name] New G-tube note no bleeding noted. A Resident Monthly S 12/30/23 at 4:45 AM o - No ER visit/hosp - Continue plan of This evidence shower inaccurately documer no ER visits for the m During a face-to-face 12:46 PM, Employee acknowledged the fin Cross Reference 22B (Facility staff failed to course of treatment in summary report for D Infection Prevention 8	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 102 A Nursing Progress Note dated 12/24/23 at 12:42 PM documented: Resident G tube was dislodged. The Physician's Assistant (PA) made aware, new order given to transfer resident to the nearest emergency room for G-tube replacement. A call was placed call to non-emergency ambulance and the resident was transferred to [Hospital name] via stretcher. A Nursing Progress Note dated 12/25/23 at 4:18 AM documented: Resident returned to unit at 5:10 PM from [Hospital name]. New G-tube noted to be intact/patent and dry, no bleeding noted. A Resident Monthly Summary Report dated 12/30/23 at 4:45 AM documented: No ER visit/hospitalization this month. Continue plan of care. This evidence showed that facility staff inaccurately documented that Resident #72's had no ER visits for the month of December 2023. During a face-to-face interview on 03/14/24 at 12:46 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated "OK." Cross Reference 22B DCMR Sec. 3231.10 (Facility staff failed to accurately document the course of treatment in Resident #72's monthly summary report for December 2023.) Infection Prevention & Control	ROVIDER OR SUPPLIER D BAPTIST NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 102 A Nursing Progress Note dated 12/24/23 at 12:42 PM documented: - Resident G tube was dislodged. - The Physician's Assistant (PA) made aware, new order given to transfer resident to the nearest emergency room for G-tube replacement. - A call was placed call to non-emergency ambulance and the resident was transferred to [Hospital name] via stretcher. A Nursing Progress Note dated 12/25/23 at 4:18 AM documented: - Resident returned to unit at 5:10 PM from [Hospital name]. - New G-tube noted to be intact/patent and dry, no bleeding noted. 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Infection Prevention & Control F 8	ROUDER OR SUPPLIER DI BAPTIST NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 102 A Nursing Progress Note dated 12/24/23 at 12:42 PM documented: - Resident G tube was dislodged. - The Physician's Assistant (PA) made aware, new order given to transfer resident to the nearest emergency or mobulance and the resident was transferred to [Hospital name] via stretcher. A Nursing Progress Note dated 12/25/23 at 4:18 AM documented: - Resident returned to unit at 5:10 PM from [Hospital name]. - New G-tube noted to be intact/patent and dry, no bleeding noted. A Resident Monthly Summary Report dated 12/23/23 at 4:45 AM documented: - No ER visit/hospitalization this month. - Continue plan of care. This evidence showed that facility staff inaccurately documented that Resident #72's had no ER visits for the month of December 2023. During a face-to-face interview on 03/14/24 at 12:46 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated "OK." Cross Reference 22B DCMR Sec. 3231.10 (Facility staff failed to accurately document in Resident #72's monthly summary report for December 2023.) Infection Prevention & Control F 880	CONTIDER OR SUPPLIER DISTRIBUTION NUMBER DISTRIBUTION NUMBER DISTRIBUTION NUMBER SUMMARY STATEMENT OF DEPICIENCIES EACH OFFICIENCY WISS TO EPPECEED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 102 A Nursing Progress Note dated 12/24/23 at 12:42 PM documented: - Resident G tube was dislodged. - The Physician's Assistant (PA) made aware, new order given to transfer resident to the nearest emergency room for G-tube replacement. - A call was placed call to non-emergency ambulance and the resident was transferred to [Hospital name] via stretcher. A Nursing Progress Note dated 12/25/23 at 4:18 AM documented: - Resident treturned to unit at 5:10 PM from [Hospital name]. New G-tube noted to be intact/patent and dry, no bleeding noted. A Resident Monthly Summary Report dated 12/230/23 at 4:45 AM documented: - No ER visithospitalization this month. - Continue plan of care. This evidence showed that facility staff inaccurately documented that Resident #72's had no ER visits for the month of December 2023. During a face-to-face interview on 03/14/24 at 12:46 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated "OK." Cross Reference 22B DCMR Sec. 3231.10 (Facility staff failed to accurately document the course of treatment in Resident #72's monthly summary report for December 2023.) Infection Prevention & Control F 880	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095020	B. WING				0
STODDAF	ROVIDER OR SUPPLIER RD BAPTIST NURSING H	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010			20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	§483.80 Infection Cor The facility must estal infection prevention and designed to provide a comfortable environmedevelopment and trandiseases and infection §483.80(a) Infection program. The facility must estal and control program (all minimum, the follow §483.80(a)(1) A systemeder of the providing services under a systemeder of the providing services under a systemeder of the providing services under a systemeder of the procedures for the probut are not limited to: (i) A system of surveil possible communicated infections before they persons in the facility (ii) When and to whom communicable disease reported; (iii) Standard and trant to be followed to prevent the provident of t	blish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable ans. Drevention and control blish an infection prevention (IPCP) that must include, at ving elements: The for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following and orders, which must include, allance designed to identify ble diseases or a can spread to other in the properties of the orinfections should be used for a tot limited to:	F	380	 Infection Prevention and Control Infection Preventionist Nurse init review of all policies immediately identify policies that required revupdates. (3/11/24). All residents can potentially be a by deficient practices. Audit was conducted by IP nurse to identify policies to be updated. (4/1/24). IP will review/update policies on infection control. Staff will be edit by IP nurse and Staff Developme policies (4/15/24 and ongoing). Report of policy updates will be submitted to QAPI by Infection Preventionist quarterly x 3. 5/14/ Completion Date: 5/17/24. Title of person(s) responsible no POC. 	riated / to riew/ ffected / ucated ent on	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095020	B. WING			C 03/20/2024	
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW WASHINGTON, DC 20010	1 03/	20/2024
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected slacontact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease of infected slacontact will transmit to (vi)The hand hygiene by staff involved in disease of infection dentified under the factorrective actions take \$483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual reverse facility will conduct the facility will conduct the facility will conduct the facility will conduct the facility stand of 25 Infection procedures, facility stand commented evidence least annually. The findings included the following policies	at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct or their food, if direct the disease; and procedures to be followed rect resident contact. The for recording incidents acility's IPCP and the en by the facility. The store, process, and to prevent the spread of the irrogram, as necessary. The is not met as evidenced the wand staff interview, for Control policies and the entire that they were reviewed at the control Policy on 03/19/24 revealed that	F	880			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095020	B. WING			C 03/20/2024	
	ROVIDER OR SUPPLIER D BAPTIST NURSING H	ОМЕ	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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
F 883 SS=D	Aureus (MRSA) Colo Control of Vancomyci (VRE) Infection (#06-Discharge Room Cleat (Non-Isolation/Infection Handling Infectious Winfection Outbreak Research (#99-013) Multiple Drug Resistat (#06-002) Reporting of In-House Communicable Diseat Treatment of Urinary Visitation During a Co-Outbreak. This binder also show Stewardship (#19-00707/22/22. During a face-to-face approximately 2:00 P Preventionist) reviewed that she did not see the reviewed. The employ work on reviewing the are based on national assessment. Cross Reference 22E Influenza and Pneum CFR(s): 483.80(d) Influenza immunizations	Resistant Staphylococcus nization (#11-015) n-Resistant Enterococcus 003) aning on Precaution Room) //aste esponse and Investigation erial Exposure Control nt Organisms (MDRO) e Infection and se (#99-01) Tract Infection ommunicable Disease //ed a policy titled, "Antibiotic 7)" that had a review date of interview on 03/18/24 at M, Employee #28 (Infection ed the policies and stated ne dates the policies were yee also said that she would e policies and ensuring they I standards and the facility's DCMR Sec. 3217.5 ococcal Immunizations (2) and pneumococcal		8880			
	immunizations	za. The facility must develop					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
				_		(
		095020	B. WING			03/	20/2024		
	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTION SHOULD BE COMPLETION DATE DATE			
F 883	each resident or the receives education repotential side effects (ii) Each resident is or immunization Octobe annually, unless the incontraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident was provided educati and potential side efferimmunization; and (B) That the resident immunization or did not immunization or did not immunization or did not immunization due to refusal. §483.80(d)(2) Pneummust develop policies that— (i) Before offering the immunization, each representative receives benefits and potential immunization; (ii) Each resident is or immunization, unless medically contraindication already been immunization or the immunization	res to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically e resident has already been es time period; e resident's representative or refuse immunization; and dical record includes idicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza ot receive the influenza medical contraindications or occoccal disease. The facility e and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal the immunization is ated or the resident has	F	8883	 Influenza education was provided residents #4 and 49 by Assistant Dof Nursing. (3/19/24). An audit was completed by Director Nursing for current residents. Iden residents who refused the vaccine educated and re-offered the influent vaccine (3/25/24). The Infection Preventionist nurse a Staff Development nurse provided education to staff, resident and far members regarding the benefits an potential side effects of Influenza immunization. (5/8/24). Administration of influenza will be reviewed during daily Clinical mee and results reported to QAPI communication preventionis (5/14/24). Correction Date 5/15/24. Title of person(s) responsible note POC. 	to Director or of tified were nza and nilly nd tings nittee t.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		095020	B. WING_			C 3/20/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		3/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 883	following: (A) That the resident was provided education and potential side effirmmunization; and (B) That the resident pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immunities and record review (2) of 41 samples failed to have docum residents or their respeducation on Influenza and Resident #49). The findings included Review of the Immunith a review date of following but not limit resident's legal repreducation regarding is side effect of immunities and preducation regarding is side effect of immunith. 1. Resident #4 was 07/02/22 with multiple Dementia. A review of the face is #4's son was her respectively.	dical record includes ndicates, at a minimum, the or resident's representative ion regarding the benefits ects of pneumococcal either received the nization or did not receive nmunization due to medical fusal. T is not met as evidenced iew and staff interviews, for d residents, facility staff ented evidence that the ponsible party received a vaccination. (Resident #4 december 10-00) Policy 07/20/23 documented the ed to, "The resident or the sentative is provided the benefits and potential zations." Is admitted to the facility on e diagnoses including sheet showed that Resident ponsible party.	F 8	83				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	, ,	COMPLETED		
		095020	B. WING _			C 03/20/2024		
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		03/20/2024		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE		
F 883	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 8					
		vas admitted to the facility on ole diagnoses including						
	#9's daughter was h A Quarterly MDS as documented a Brief	e sheet showed that Resident her responsible party. ssessment dated 08/02/23 Interview for Mental 7, indicating the resident has						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
095020		B. WING			C 03/20/2024		
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME				1	STREET ADDRESS, CITY, STATE, ZIP CODE 818 NEWTON ST. NW VASHINGTON, DC 20010	1 03/	20/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 883	Care Report (Influenze documented the follow "Administered Yes-In Date/Time 09/26/23 a Intramuscular, Site - I Provided to Resident (power-of-attorney) - document showed that Provided By- was blat was not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided by such as not provided (adventually 10:43 to 1	at titled, "Preventive Health a Vaccine)" dated 09/26/23 wing but not limited to, house, Administration at 12:24 PM, Route - Left Deltoid, and Education (Family/POA) No." Continued review of the at section and Education nk indicating that education staff. So (vital signs). [blood se] 67, [respiration] 18, sident received 0.5 ml left deltoid IM 70274 exp, (expiration) real record lacked that education regarding intial side effect of the (immunization) was ent or her responsible party. Interview on 03/18/24 at AM, Employee #22 stated that the facility's and/or their responsible education on the benefits ent of vaccines on admission	F	883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	095020 B. WING			C 03/20/2024			
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME				18	REET ADDRESS, CITY, STATE, ZIP CODE 18 NEWTON ST. NW ASHINGTON, DC 20010	1 001	20/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 883 F 908 SS=D	the residents or their provided education of Essential Equipment, CFR(s): 483.90(d)(2) Substitute 1 Substitute 2 Substitut	d that she did not see that responsible parties were in the Influenza vaccine. Safe Operating Condition In all mechanical, electrical, present in safe operating It is not met as evidenced In sand staff interview, facility in essential equipment in elenced by one (1) of one (1) warmer, and two (2) of four (1) of one (1) gas stove that tested. In dietary services on proximately 9:00 am: In dietary services on proximately 9:00 am: In dietary services on proximately 9:00 am: In dietary services on proximately 9:00 am:			 F908 Essential Equipment in Safe Opera Condition Dining Director notified Maintenance Director regarding equipment. Repapellet warmer, 2 food burners and gatove were done on 3/5/24. Maintenance Director completed assessment of kitchen equipment a found all equipment in working orderesidents were impacted by this pra 3/12/24. Dining Director to check temperatur warming pallets weekly to ensure thare in working order and heat at temperature of at least 1750. Tempreadings are documented on Safety Log maintained in kitchen. Gas burnare checked daily before use and ordocumented on Safety Check Log (5/17/24). Any problems identified wreported to Maintenance immediate Dining Director to report operating condition of kitchen equipment to Q committee quarterly x 3 quarters. (5/14/24). Correction Date 5/17/24. Title of person(s) responsib1e noted POC. 	e airs to las and er. No ctice. The of last they erature of Check hers condition will be aly.	
		vere acknowledged by a face-to-face interview on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
095020			B. WING _				
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 908	. •	e 111 pproximately 3:30 PM.	F 9	08			