STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	11/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Stoddard Baptist Nursing Home from November 15, 2016, 2016 through November 18, 2016. Survey activities consisted of a review of 40 resident clinical records during Stage 1; and review of 45 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews for 45 sampled residents. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status g-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter	F 000	Please begin typing your responses here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Makeeta Johnson, LNHA | TITLE: ADMINISTRATOR | (X6) DATE: 12-23-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - Interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, R/P- Responsible Party PO- By Mouth	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		

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F 272	Continued From page 2 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 45 sampled residents, it was determined that facility staff failed to accurately code the admission Minimum Data Set (MDS) under Section H (Bladder and Bowel) for Resident # 61. The findings include:	F 272		

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F 272	Continued From page 3 A review of the admission MDS dated June 3, 2016 revealed that Resident #61 was coded under Section H (Bladder and Bowel) as "always continent for urine and bowel. " A review of the Resident #61 ' s ADL (Activities of Daily Living) record revealed the following episodes of urinary incontinence: May 27, 2016 - Times incontinent - 4 May 28, 2016 - Times incontinent - 5 May 29, 2016 - Times incontinent - 6 May 30, 2016 - Times incontinent - 6 May 31, 2016 - Times incontinent - 5 June 01, 2016 - Times incontinent - 3 June 02, 2016 - Times incontinent - 5 June 03, 2016 - Times incontinent - 3 A face-to-face interview was conducted with Employee #10 at approximately11:00 AM on November 16, 2016. After reviewing the MDS, he/she acknowledged that the MDS was not coded to accurately reflect the resident's urinary continence status. The record was reviewed on November 16, 2016.	F 272	1. Resident #61 MDS was corrected and retransmitted on 12/19/16. 2. All other resident MDS were checked for accurate coding, corrections were made if required. 3. The nurse educator and the DON provided in-service to all MDS staff on accurate coding on 12/19./16 4. Accurate coding for MDS will be monitored and reported to QAPI quarterly. 5. Completion date 12/19/16	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 45 Stage 2 sampled residents, it was determined that facility staff failed to follow physician's orders for the application of a topical medication patch for pain (Salonpas Patch) for one (1) resident and failed to follow through on a dental recommendation to obtain a mandibular x-ray (photographic image of the mouth) from an outside consultant in a timely manner for one (1) resident. Residents' #5 and #13. The findings include: 1. Facility staff failed to follow physician's orders for the application of a Salonpas Patch (an over-the-counter topical pain patch for the temporary relief of mild to moderate pain) for Resident #5. During the medication pass observation on November 18, 2016 at approximately 8:59 AM, the nurse was observed preparing Resident #5's medications, one of which included Salonpas Patch. Resident #5 stated to Employee #16, "my pain patch was not removed on the other shift [11-7] and I could not reach it to take it off." The resident pointed to his/her left shoulder and the Salonpas patch was observed on the resident ' s left shoulder. A review of the physician ' s orders signed and dated October 2, 2016 directed, "Salonpas patch topical to be applied to left shoulder q [every]12hrs [hours] -[for] Pain to the shoulder."	F 309	F309 1. Salonpas Patch on resident #5's left shoulder was removed immediately and the resident was assessed on 11/18/16. No adverse effect was noted. 2. All other residents with physician order for medication patch application were checked and all were carried as ordered by the attending physician. 3. The nurse educator provided in-service to all licensed staff on medication pass, including application and removal of topical medication patch. 4. Medication pass, including application and removal of topical medication patch will be monitored and reported to QAPI quarterly. 5. Completion date: 12/22/16	

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F 309	Continued From page 5 A review of the Medication Administration Record (MAR) for November 2016 revealed the following: "[Salonpas] Camphor -Menthol-Methyl Sal ... patch topical apply to left shoulder [every] 12 hours ... Time: on at 9:00AM; off 9:00PM." A review of the November 2016 MAR revealed that the Solapanos patch was "off at 9 PM" on November 17, 2016. A face-to-face interview was conducted with Employee # 4 on November 18, 2016 at approximately 9:10 AM, after review of the physician order, he/she acknowledged the findings. The observation was conducted on November 18, 2016. 2. Facility staff failed to follow through on a dental recommendation to obtain a mandibular x-ray from an outside consultant in a timely manner for Resident #13. An " Interim Physician ' s Order " dated and signed September 13, 2016 at 5:30 PM directed: " Obtain medical and family clearance, then make an appointment at [Dentist Name] office [phone number provided] to have x-ray taken of mandibular anterior area causing pain... " A review of the dental " Oral History and Record of Consultations " dated September 13, 2016 revealed " Order written for x-rays and extraction of all pathologically involved mandibular anterior teeth causing pain. " In response to a query regarding the results of the resident ' s mandibular x-ray, facility staff called the radiologic contractor (out-of-facility	F 309	F309 – Resident #13 1. Complete assessment was performed on Resident #13 immediately. There was no evidence of any untoward effect. Resident is her own point of contact. The resident was scheduled for appointment on November 28, 2016 at 3:00 pm with Dr. Bernard Milton. The resident later refused to go for the appointment. Another appointment has been made for February 2, 2017 with Dr. Bernard Milton. 2. All other residents medical record were reviewed for completion by requested diagnostic studies. All other diagnostic studies were completed if required. 3. The nurse educator provided in-service on follow-up procedures for residents with physician recommendations for diagnostic studies. 4. Resident with physician recommendations for diagnostic studies will be monitored for timely follow up and reported to QAPI quarterly. 5. Completed date 12/19/16.	

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F 309	Continued From page 6 provider) to obtain the report, however; determined that no x-ray had been performed for Resident #13. The record lacked evidence that Resident #13 underwent an x-ray of the mandible. There was a period of approximately 64 days that lapsed from the time of this review and the physician ' s initial recommendation for x-rays. There was no evidence that the experienced any untoward effect(s) from the delay. A face-to-face interview was conducted with Employee #4 on November 17, 2016 at approximately 1:30 PM regarding the aforementioned findings. He/she acknowledged the mandibular x-ray was not performed as recommended. The clinical record was reviewed on November 17, 2016.	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on November 15, 2016 at approximately 8:05 AM, it was determined that the facility failed to prepare foods	F 371		

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F 371	Continued From page 7 under sanitary conditions as evidenced by two (2) of two (2) convection ovens and one (1) of one (1) coffee machine that were soiled on the inside and one (1) of one (1) steamer and two (2) of two (2) convection ovens that were soiled at the top. The findings include: 1. Two (2) of two (2) convection ovens and one (1) of one (1) coffee machine were soiled on the inside. 2. The top of one (1) of one (1) steamer and of two (2) of two (2) convection ovens was soiled with dust. These observations were made in the presence of Employee #11 and /or Employee #12 who acknowledged the findings.	F 371	F371 1. The 2 convection ovens, coffee machine and steamer were cleaned immediately 2. All other kitchen equipment were checked for cleanliness and cleaned as needed. 3. The Dining Service Director provided an in-service on procedures for cleaning and established cleaning schedule/assignment. 4. The QAPI Director or designee will conduct weekly inspection of kitchen equipment and report to QAPI monthly. 5. Completion date:12/22/16	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 45 Stage 2 sampled residents, it was determined that the physician failed to include the diagnosis of Herpes Simplex Virus for Resident	F 386		

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F 386	Continued From page 8 #75 who received active treatment for the disorder. The findings include: The physician failed to include in his/her total plan of care the diagnosis of Herpes Simplex Virus for Resident #75. An interim order dated November 15, 2016 at 4:00 PM directed, "Zovirax (antiviral drug) 5% cream to external labia BID (twice a day) for genital herpes [times] 7 days." A review of the nursing notes dated November 15, 2016 at 9:00 PM revealed "...Comments: Resident observed with redness and rashes to vaginal area this shift, NP (Nurse Practitioner) on the unit, made aware, assessed resident. Order given for Zovirax 5% cream- topical to the labia area BID (twice a day) [times] seven (7) days for genital herpes... " A review of the comprehensive care plan updated November 15, 2016 revealed, "Problem: infection related to: genital herpes to the external labia, ... administer medications as ordered ... administer Zovirax 5% cream to the external labia BID for genital herpes [times] 7 days ... " A review of the physician progress notes lacked evidence of any documentation regarding his/her assessment and diagnosis of genital herpes. A face-to-face interview was conducted with Employees #2 and #4 on November 18, 2016 at approximately 3PM. After reviewing the clinical record, both acknowledged the aforementioned findings. The clinical record was reviewed on	F 386	1. A late entry documentation from the nurse practitioner regarding her assessment and diagnosis of genital herpes was completed for Resident #75 on 12/19/16. 2. All other Physician and nurse practitioners documentation regarding assessment, diagnosis of disease and other pertinent condition were reviewed. Corrections were made if required. 3. The medical director provided in-service to the nurse practitioner on documentation after each resident assessment. 4. Physicians and nurse practitioner assessment documentations will be monitored and reported to QAPI quarterly. 5. Completed date: 12/19/16	

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F 386	Continued From page 9 November 18, 2016.	F 386		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 45 Stage 2 sampled residents, it was determined that the attending physician failed to provide a rationale in one (1) resident ' s medical record for the recommended dose reduction by the pharmacist of an antidepressant medication. Resident #65. The findings include: The pharmacist ' s " Note (s) to Attending Physician/Prescriber" revealed the following: January 21, 2016- [Pharmacist note] " ... Please consider gradual dosage reduction of Trazodone(antidepressant) 25mg HS (hour of sleep) ... Physician/Prescriber Response: No dose	F 428	F428 1. The Pharmacy recommendation for a gradual dose reduction for Trazadone for resident #65 was completed by the physician on 11/27/16. No untoward reaction noted from previous dosage. 2. All other residents with pharmacy recommendations for gradual dose reduction for psychotropic medications were reviews. Corrections were made if needed. 3. The nurse educator provided in-service to the NP/MD/licensed staff on following up and documentation for gradual dose reduction for psychotropic medications. 4. Residents on psychotropic medications will be monitored for gradual dose reduction and reported to QAPI quarterly. 5. Completed date:12/22/16	

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F 428	Continued From page 10 reduction indicated [at] this time ... " April 7, 2016- [Pharmacist note] " ... Please consider gradual dosage reduction of Trazodone 25mg H. PRN (as needed) ... Physician/Prescriber Response: Dose reduction not indicated [at] this time ... " July 28, 2016- [Pharmacist note] " ... Consider Trazodone gradual dosage reduction (survey guidelines); .... Physician/Prescriber Response: Resident hospitalized [at] present ..." A review of a "Psychiatric Evaluation " dated February 18, 2016 revealed: " ...[resident named] sleep is " so-so ", despite being on Trazodone 50mg QD (every day) ... " Recommendations: Staff to document sleep ..." A review of the nursing notes and the behavior monitoring sheets revealed no documentation related to resident having symptoms of problem sleeping. A review of the physician progress notes from February 2016 to September 2016 lacked evidence of any documented rationale to continue Trazadone 50mg daily from January 2016 to November 17, 2016. A face-to-face interview was conducted on November 17, 2016 at approximately 3:00 PM with Employees #2 and #4. Both acknowledged	F 428		

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F 428	Continued From page 11 that Resident had been on Trazadone since January 2016 and there has been no evidence of a gradual dose reduction or a rationale to for continuance of Trazadone. The record was reviewed on November 17, 2016.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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F 441	Continued From page 12 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on a review of employee records for 10 of 10 newly hired employees and through staff interview, it was determined that facility staff failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection as evidenced by a failure to ensure that three (3) of 10 newly hired employees were screened for communicable disease such as Mycobacterium Tuberculosis (TB) upon hire and/or prior to providing direct care to residents in the facility. Employees #8, #9 and #10. The findings include: Centers for Disease Control (CDC's) Prevention Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly Reports (MMWR) 2005:54(RR17); 1-141 stipulates: "Two-step testing with the Mantoux tuberculin skin test (TST) should be used for baseline or initial testing. Some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection. "	F 441		

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F 441	Continued From page 13 <https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm> "TB Screening Procedures ... all HCWs (health care workers) should receive baseline screening upon hire ...HCWs should receive TB screening annually (i.e., symptom screen) for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results...HCWs with a baseline positive or newly positive...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually." 1. The facility failed to ensure that Employee # 8 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee # 8's personnel file revealed the following: Job Title: Graduate Social Work (GSW) Date of Hire: May 23, 2016 There was no evidence that Employee #8 was offered or received the two-step Purified Protein Derivative (PPD) skin test [a test that determines if you suffer from tuberculosis], a chest x-ray or the Tuberculosis Symptom Screening Questionnaire as applicable, prior to or upon employment. 2. The facility failed to ensure that Employee # 9 was pre- screened for communicable disease	F 441	1. Employee #8, 9, 10 were all offered and received a second PPD skin test. All had negative result. 2. All other employee records were reviewed for evidence of baseline 2 step PPD or current chest x-ray. There were no other employees without current 2 step PPD or chest x-ray. 3. All employees, including Human Resource Department personnel were provided in-service education on the process for TB screening and availability of documents upon hire. Facility policy was revised to reflect current CDC guidelines. 4. All documentation for new hire will be reviewed by the Infection Prevention nurse for availability of current chest x-ray or 2 step TB screening and reported to QAPI quarterly. 5. Completion date 12/23/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 14 prior to employment in accordance with regulations and guidelines. A review of Employee # 9's personnel file revealed the following: Date of Hire: May 23, 2016; Job Title: Certified Nurse Assistant (CNA) There was no evidence that Employee #9 was offered or received the two-step Purified Protein Derivative (PPD) skin test, a chest x-ray, or the Tuberculosis Symptom Screening Questionnaire as applicable, prior to or upon employment 3. The facility failed to ensure that Employee # 10 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #10's personnel file revealed the following: Job Title: Registered Nurse (RN); Date of Hire: March 7, 2016 There was no evidence that Employee #10 was offered or received the two-step Purified Protein Derivative (PPD) skin test, a chest x-ray, or the Tuberculosis Symptom Screening Questionnaire as applicable, prior to or upon employment. Further review of Employees ' #8, #9 and# 10's personnel records lacked documented evidence of pre- employment testing for communicable diseases upon hire. A face-to-face interview was conducted with the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	11/18/2016

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F 441	Continued From page 15 Employees' # 1 and #2 on November 14, 2016 at approximately 11:00 AM. After further review, they both acknowledged the aforementioned findings. The records were reviewed on November 19, 2016.	F 441		