Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0019	A. BUILDING: _____ B. WING _____	01/28/2014

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

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L 000	Initial Comments A Licensure Survey was conducted on January 28, 2014. The deficiencies are based on observation, interview and record review for 28 sampled residents.	L 000	Please begin typing your responses here:	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 38 sampled residents, it was determined that facility staff failed to prescribe nurse pronouncement directives consistent with the District ' s law. Residents 118, 124, 181. The findings include: Pursuant to District of Columbia District of Columbia Law 4-34; D.C. Code §6-201; Act 9-299, Section 2, "To amend the Vital Records Act of 1981 to provide that the certificate of death shall contain a pronouncement of death section separate from the medical certification of cause of death section ...to authorize a funeral director to remove a decedent ' s remains following a medically expected death on the authority of a pronouncement of death signed by an attending registered nurse or treating physician ... " Section 2 paragraph (4A) " Expected death " means a death from a previously diagnosed illness with a prognosis of death in less than 6	L 001		

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L 001	Continued From page 1 months... " 1. A review of the medical record for Resident #118 revealed the medical practitioner failed to prescribe nurse pronouncement directives consistent with District of Columbia Law 4-34; D.C. Code §6-201, D.C. Act 9-299; Section 2, " Expected Death ... " Interim orders signed by the nurse practitioner directed: " DNR/DNI [don not resuscitate or intubate]; No hospitalization, no labs, no IV [intravenous] fluids, no weights; RN Pronouncement. " The orders and/or medical team progress notes lacked evidence that the resident ' s illness included a prognosis of death in less than 6 months. A review of Section J1400, Prognosis, of the quarterly Minimum Data Set dated October 15, 2013 was coded as " no " in response to the question of life expectancy of less than 6 months. There was no evidence that the medical team prescribed nurse pronouncement directives in accordance with state law. The record lacked evidence of expected death for Resident #118. The record was reviewed January 27, 2014. 2. A review of the medical record for Resident #124 revealed the medical practitioner failed to prescribe nurse pronouncement directives consistent with District of Columbia Law 4-34; D.C. Code §6-201, D.C. Act 9-299; Section 2, "	L 001	1. Medical record of Resident #118, #124, #181 were amended to reflect compliance with DC Law 4-34 on nurse pronouncement to include resident's illness and prognosis of death with 6 months. 2. All other resident records with orders for RN pronouncement were reviewed and new orders written to reflect compliance with DC Law 4-34 on nurse pronouncement on 1/31/14 to include resident illness and prognosis of death within 6 months. 3. In-service education was provided to licensed staff regarding DC Law 4-34, nurse pronouncement. Policy on RN pronouncement was revised to reflect need to include residents illness and prognosis of death within 6 months. 4. Nurse pronouncement orders will be monitored by licensed nurses and reported to QAPI quarterly. 5. Completion date	1/31/14 2/28/14 2/28/14

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L 001	Continued From page 2 Expected Death ... " Interim orders signed by the nurse practitioner directed: " DNR/DNI [don not resuscitate or intubate]; No hospitalization, no labs, no IV [intravenous] fluids, no weights; RN Pronouncement. " The orders and/or medical team progress notes lacked evidence that the resident ' s illness included a prognosis of death in less than 6 months. A review of Section J1400, Prognosis, of the admission Minimum Data Set dated November 20, 2013 was coded as " no " in response to the question of life expectancy of less than 6 months. There was no evidence that the medical team prescribed nurse pronouncement directives in accordance with state law. The record lacked evidence of expected death for Resident #124. The record was reviewed January 27, 2014. 3. A review of the medical record for Resident #181 revealed the nurse practitioner failed to prescribe nurse pronouncement directives consistent with District of Columbia Law 4-34; D.C. Code §6-201, D.C. Act 9-299; Section 2, " Expected Death ... " Interim orders prescribed by the nurse practitioner dated January 16, 2014 at 2PM directed: " DNR/DNI [don not resuscitate or intubate]; No hospitalization, no labs, no IV [intravenous] fluids, no weights; RN Pronouncement. "	L 001		

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L 001	Continued From page 3 The orders and/or medical team progress notes lacked evidence that the resident ' s illness included a prognosis of death in less than 6 months. A review of Section J1400, Prognosis, of the admission Minimum Data Set dated October 2, 2013 was coded as " no " in response to the question of life expectancy of less than 6 months. There was no evidence that the medical team prescribed nurse pronouncement directives in accordance with state law. The record lacked evidence of expected death for Resident #181. The record was reviewed January 24, 2014.	L 001		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and	L 052		

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L 052	Continued From page 4 infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations and interview for one (1) of 38 sampled residents, it was determined that sufficient nursing time was not given to assist Resident #83 to exercise personal preference as evidenced by failing to allow the resident an opportunity to be seated in the common area when desired. Resident #83 The findings include:	L 052	1. Resident #83 was immediately moved to the common area as desired on 1/27/14. There were no negative outcomes to the resident. 2. All other residents in their rooms were asked if they wished to be in the common area. No other resident verbalized desire to be moved to the common area. 3. Educational in-service was provided to all staff on Adherence to Resident Personal Preference, Resident Right to Choose Activities, Schedules and Health Care Consistent with His or Her Care Plan on 3/5/14. 4. Resident Right to Choose Activities, Schedules and Health Care Consistent with Plan of Care will be monitored every shift and reported monthly. 5. Completion date 3/5/14	3/5/14

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L 052	Continued From page 5 On January 23, 2014 at approximately 10:45 AM, Resident #83 was observed seated in a recliner geriatric chair in his/her room behind the drawn curtain. The resident responded affirmatively in a very soft tone to a request for entry into his/her room. The resident was observed with a Gastrostomy tube attached to an enteral feeding that was infusing via infusion pump. Resident #83 had a grimace on his/her face. In response to a query whether or not he/she was uncomfortable, he/she nodded " no. " In response to a query regarding plans for the morning, Resident #83 responded affirmatively to a desire to leave the room and sit in the common area [day room] in the company of others. An interview was conducted with the resident ' s assigned nurse, Employee #11 following the interaction with Resident #83. Employee #11 was informed that Resident #83 expressed a desire to be seated out of his/her room into the common area. Employee #11 stated that the resident would need to wait until the afternoon once his/her enteral feeding was complete because there was no place in the day room to plug the infusion pump. He/she added that resident ' s geriatric chair would obstruct the passageway if plugged into the outlet along the corridor in the common area. Facility staff failed to assist Resident #83 to fulfill his/her choice to be seated in the common area in the company of others. The findings were acknowledged during a face-to-face interview with Employee #5 on January 23, 2014 at approximately 3:00 PM. However, Employee #5	L 052		

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L 052	Continued From page 6 stated that there were accommodations available in the day room for Resident #83 and that staff would be educated.	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on January 22, 2014 at approximately 2:15 PM, it was determined that the facility failed to store food utensils under sanitary conditions as evidenced by four (4) of four (4) six-inch half-pans, seven (7) of seven (7) two-inch one-third pans, 11 of 11 four-inch one-quarter pans and five (5) of five (5) one-half sheet pans that were stacked wet on a storage rack. Based on observations made on January 22, 2014 at approximately 2:15 PM, it was determined that the facility failed to store food utensils under sanitary conditions as evidenced by four (4) of four (4) six-inch half-pans, seven (7) of seven (7) two-inch one-third pans, 11 of 11 four-inch one-quarter pans and five (5) of five (5) one-half sheet pans that were stacked wet on a storage rack. The findings include: 1. Four (4) six-inch half-pans, seven (7) two-inch one-third pans, 11 four-inch one-quarter pans and five (5) one-half sheet pans stored wet.	L 099	L099 1. The dietary staff stacked wet utensils on a storage rack that did not meet regulatory guidelines. Four (4) six-inch half pans, seven (7) two-inch one-third pans, eleven (11) four-inch one quarter pans and five (5) one-half sheet pans were removed from storage racks on 1/22/14. All above utensils were washed again per regulatory guidelines and placed on dry rack surface until utensils were completely dry. The dried utensils were then placed on the storage rack. 2. There were no other dishes/utensils observed in similar condition. 3. In-services were provided to the Dietary Department staff regarding Sanitation/preparation and Storage of Utensils per Regulatory Guidelines. 4. Sanitation and Storage of Dietary Utensils will be monitored and reported to the QAPI Committee quarterly. 5. Complete date:	3/8/14

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L 099	Continued From page 7 These observations were made in the presence of the Director of Food Services who acknowledged the findings.	L 099		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on three (3) of 38 resident interviews and test tray observations on two (2) of three (3) residential units, it was determined that facility staff failed to serve hot foods at preferable temperatures. Residents #68, 106 and 154 The findings include: Three (3) of 38 sampled residents communicated that meals were not served at the proper temperature as follows: During a face-to-face resident interview on January 23, 2014 at approximately 9:00 AM; in response to the question, " Is the food [hot food] served at the proper temperature? " Resident #68 replied " Breakfast is always cold. " During a face-to-face resident interview on January 23, 2014 at approximately 10:45 AM; in response to the question, " Is the food [hot food] served at the proper temperature? " Resident #106 replied " My food is cold every day. " During a face-to-face resident interview on January 23, 2014 at approximately 3:00 PM; in	L 108	L 108 1. Resident # 68, 106 and 154 were assessed on 1/23/14. No corrective action could be done for the residents identified during this timeframe. There were no negative outcomes to residents. 2. All the appropriate residents were assessed and interviewed by dietary staff regarding their satisfaction of hot food being served on 1/23/14 and the residents did not complain about the food temperature. 3. In-service education were provided to the Dietary Department staff regarding required regulatory guidelines for Food Temperatures. Steam tables temperatures were adjusted to ensure compliance with proper hot food temperature. 4. Food temperatures for residents will be monitored through resident interviews and test trays monthly and reported to QAPI quarterly. 5. Completion date:	3/8/14

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L 108	Continued From page 8 response to the question, " Is the food [hot food] served at the proper temperature? " Resident #154 replied " most of the time, food is cold. " Food temperatures were tested on January 23, 2014 at approximately 12:15 PM during the lunch meal service by way of " test tray " on the second and third floors. Hot food temperatures were measured at temperatures less than 140 degrees Fahrenheit as follows: Second floor Third floor Liver and Onions 122 degrees F 117 F Mashed potatoes 126 F 135 F Collard Greens 115 F 130 F Puree Greens 153 F 139.8 F Puree Meat 125 F 126 F Facility staff failed to serve hot foods at preferable temperatures as evidenced by resident interview and observation via " test tray. " The test tray observations were made in the presence of Employee #10 on January 23, 2014 who acknowledged the findings.	L 108		
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and	L 199		

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L 199	Continued From page 9 serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on observation, record review and interview for two (2) of 38 sampled residents, it was determined that the dentist failed to record an assessment and plan of care for one (1) resident observed with broken teeth and licensed staff failed to sign and date the dialysis communication logs for one (1) resident. Residents #18 and 41. The findings include: 1. An observation of Resident #18 on January 22, 2014 at approximately 3:30 PM revealed the resident had broken teeth that appeared to have plaque residue on the surface. In response to a query regarding whether or not he/she received assistance with brushing teeth, Resident #18 stated " I brush them myself ...they get my toothbrush for me. " The resident replied " no " when asked if he/she had any teeth pain or oral problems. A review of dental examination progress notes in the clinical record revealed the most recent dental examination was May 28, 2013. The dentist recorded " Oral assessment " in the progress note section of the dental examination. There was no further evidence of documentation related to the oral examination for May 28, 2013. The dentist failed to record a dental assessment and plan of care for Resident #18 ' s oral health. The findings were acknowledged during a	L 199	1. The dentist for resident #18 was notified regarding need for oral assessment. Dentist visited resident on 2/4/14 but resident declined oral assessment. 2. All other resident charts were reviewed for evidence of oral assessment 0n 2/4/14. All other residents had documentation of comprehensive oral assessment. 3. Educational in-service provided to the dentist by the medical director regarding documentation of oral assessment and plan of care. Oral assessment form was reviewed and revised on 3/4/14. 4. Comprehensive dental assessment documentation will be monitored monthly and reported to QAPI quarterly. 5. Completion date:	3/14/14

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L 199	Continued From page 10 face-to-face interview with Employee #4 on January 27, 2014 at 4:00 PM. The record was reviewed January 24, 2014. 2. Facility staff failed to sign and date dialysis communication logs for Resident #41. A review of the dialysis communication log records revealed that on March 16, 2013, April 2, 2013, April 4, 2013, April 13, 2013, and September 19, 2013 the Charge Nurse/Team Leader failed to date and record a signature in the allotted space. The space designated for signature and date remained blank. A face-to-face interview was conducted on January 27, 2014 at approximately 10:00AM with Employee # 5. After reviewing the dialysis communication logs, he/she acknowledged the findings. The record was reviewed on January 27, 2014.	L 199	1. Resident #41 – Communication log was reviewed, signed and dated as needed, 2. There are no other residents on dialysis in the facility. 3. In-service education was provided to licensed nurses regarding accurate notation on dialysis communication log. 4. Dialysis communication log will be monitored by Director o Nursing monthly and reported to QAPI quarterly. 5. Completion date	1/27/14 3/8/14