PRINTED: 12/16/2009
FORM APPROVED

Health Regulation 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 _____	11/09/2009

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 An annual licensure survey was conducted November 3 through 9, 2009. The following deficiencies were based on observations, record review, staff and resident interviews. The sample included 24 residents based on a census of 159 residents on the first day of survey and nine (9) supplemental residents.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 24 sampled records, it was determined facility staff failed to develop a plan of care to	L 051		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

12/29/09

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L 051	Continued From page 1 address significant weight loss for one (1) resident and that facility staff failed to update care plan status post fall. for one (1) resident. Residents' #10 and M1 The findings include: A. A review of the plan of care for Resident #10 lacked problem identification, objectives and approaches to care for significant unplanned weight loss sustained by the resident. According to a dietary progress note dated June 4, 2009, Resident #10 sustained a significant weight loss over the past 90 days. Nutritional interventions were implemented to address the resident ' s weight loss and a dietary progress note dated September 8, 2009 revealed the resident sustained significant weight gain and weight stabilization as of October 5, 2009. A face-to-face interview was conducted with Employee #5 on November 6, 2009 at approximately 3:00 PM. In response to a query regarding the care plan related to the resident ' s weight loss, he/she acknowledged that the problem list lacked evidence of a nutritional care plan. However, Employee #5 requested an opportunity to research further and returned with care plan problem #292 that identified " Resident has hypertension. " Included in this care plan were notations related to the resident ' s weight loss. The clinical record lacked evidence that facility staff developed a plan of care related to the resident ' s weight loss and nutritional needs. The record was reviewed November 6, 2009. B. Facility staff failed to update care plan status	L 051	Resident #10 1. The resident was assessed and care plan was updated to address weight loss and nutritional intervention for weight gain. 2. All other residents care plans with weight loss were checked and no discrepancies were found. 3. Resident Care Coordinators and members of the Interdisciplinary Team were provided in-services on Updating Resident Care Plans on 12/1/09. 4. Resident care plans will be monitored monthly by Resident Care Coordinators and reported through CQI quarterly. 5. Complete date 12/24/09.	

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L 051	Continued From page 2 post fall for resident # M1. A review of care plan dated August 26, 2008 for potential for injury/fall related to unsteady gait, impaired vision ... and history of falls revealed that the resident fell on January 5, 2009, March 22, 2009, April 1, 2009 and April 26, 2009. Three (3) hand written notations were made under the Interventions column of the care plan. These hand written notations were not dated. (1)-Caregiver to call for assistance when getting resident out of bed (2)-Alarm on wheelchair when out of bed (3) Apply seatbelt to prevent fall. May release Seatbelt A further review of the record and a face to face interview was conducted with Employee #5 and Employee #27 on November 6, 2009 at 10:30 AM. These employees stated: January 1, 2009 fall - the CNA caregiver was educated March 22, 2009 fall- Alarm on wheelchair when out of bed April 26, 2009 fall- Apply seatbelt to prevent fall. May release Seatbelt. In an interview with Employee# 3 on November 6, 2009 about 3:00 PM it was stated " the missing intervention [For the April 1, 2009 Fall] is that we put the resident in a wheelchair " A Nursing Monthly Summary Dated April, 09 and signed April 19, 2009 by LPN and April 22, 2009 by RN States: " Fell on 04/01/09 [April 1, 2009], sustained no injuries. Continue to wander around the unit with close monitor. No hospitalization. On Ativan 0.5mg QD [everyday] for agitation. Denies pain and discomfort.	L 051	Resident #M1 1. Resident #M1's care plan was updated and reviewed on 11/9/09. 2. All other resident care plans with previous falls were reviewed and no discrepancies were found. 3. Resident Care Coordinators and members of the Interdisciplinary Team were provided in-service on Updating Resident Care Plans on 12/1/09. 4. Resident care plans will be monitored monthly by Resident Care Coordinators and reported through CQI quarterly. 5. Completion date 12/24/09.	

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L 051	Continued From page 3 Addendum [no date] Resident gait unsteady, non compliance for sitting on chairs. Due to multiple fall resident [to] use wheelchair for mobility " The record contained no evidence that the Care plan was updated after fall of April 1, 2009,untill the fall of April 27, 2009	L 051		
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 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	L 052		

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L 052	Continued From page 4 (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 observation, record review and staff interview for seven (7) of 24 sampled residents, it was determined that the charge nurse failed to follow physician ' s order for Orthopedic Consult and use of a seat belt for one (1) resident, to discontinue wound treatment per physician ' s order for one (1) resident, to follow through on an order for a GI consult for one (1) resident, to monitor pain and obtain a physical therapy consult for one (1) resident, failed to safely transfer three (3) residents to prevent accidents and/or injuries and to provide care to prevent development of a pressure ulcer for one resident . Residents #2, 7, 10, 16, 19, 20 and D1. The findings include: 1. The charge nurse failed To follow physician ' s order for Orthopedic Consult and use of a seat belt while out of bed for Resident #2. A.. A review of Resident #2 ' s record revealed a physician ' s telephone order dated July 2, 2009	L 052	Finding #1 1. There was no orthopedic consult ordered for Resident #2. The Nurse Practitioner discontinued the vascular consult on 12/18/09. The Attending Physician discontinued the order for a seat belt for Resident #2 on 11/4/09. 2. Residents with orders for seat belts are being monitored to ensure that the residents are wearing their seat belts. Residents with orders for physician consults were reviewed to ensure that appointments had been scheduled. 3. In-service was provided for nursing staff on physician consults and monitoring residents with seat belts on 12/17/09, 12/18/09, 12/20/09, 12/22/09. 4. Physician consults and monitoring residents with seat belts will be monitored monthly by Resident Care Coordinators and reported quarterly through CQI. 5. Completion date 12/24/09.	

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L 052	Continued From page 5 and signed July 5, 2009 which requested Vascular Consult with (MD ' s name) on July 7, at 12:30PM. Further review of the clinical record failed to reveal any documentation depicting the scheduled appointment, result of the consultation or an order cancelling the order for the consultation. A face-to-face interview was conducted with Employee #5 at approximately 11:55AM on November 4, 2009. He/she stated that, " His wife did not want him to have any more tests. The doctor called and told us to cancel the appointment with the vascular doctor. When the nurse wrote the order to cancel the appointment she omitted to cancel the Aortogram with Peripheral Run-Off. Those tests were requested by the vascular surgeon and if he/she was not going to see him/her then there was no need to have the tests. " In another face-to-face interview with Employee #5 at approximately 2:30PM, he/she stated, " I spoke to the doctor at 2:00PM and he/she gave me an order to cancel the test. " The record was reviewed on November 3, 2009. B. A review of Resident #2 ' s record revealed a physician ' s telephone order dated August 20, 2009 and signed on September 2, 2009 which directed " Seat belt while out of bed. Release as necessary. " A review of a quarterly Minimum Data Set dated August 27, 2009 revealed that the resident was coded with a (2) in Section P4c indicating that the resident used the seat belt daily. The resident was observed sitting in a wheel	L 052		

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L 052	Continued From page 6 chair without a seat belt at 1:30PM on November 3, 2009 and at 9:00AM and 1:30PM on November 4, 2009. A face-to-face interview was conducted with Employee #5 at approximately 1:45PM on November 4, 2009. He/she acknowledged that the resident was not wearing a seat belt while out of bed. The record was reviewed on November 3, 2009. 2. Charge nurse failed to discontinue wound treatment orders per physician orders for Resident #7. Resident #7 was observed with a white dressing wrapped around his/her lower right leg. White colored stockings covered the dressing. During an interview with Resident #7 he/she stated that the "nurse" applied the dressing to his/her leg. Review of the interim order form dated August 19, 2009 directed " (1) bilateral lower extremity arterial venous doppler studies Diagnosis: swelling/wound (2) cleanse open area Right leg with Normal Saline (NS) apply Aquaphor ointment then 4X4/tape daily until resolved (3) Apply Aquaphor ointment to lower extremity daily for dryness. " A review of the Physician ' s Order Sheet signed October 30, 2009 directed. "cleanse right leg open area with NS, apply Aquaphor ointment daily then 4x4/tape daily until healed. According to the facility's "Skin Assessment Sheet " dated September 11, 2009, Resident #7's right leg open area was resolved. A review of the September 2009 Treatment	L 052	Finding #2 – Resident #7 1. Physician order for aqua ointment with 4x4 dressing was discontinued on 11/5/09. Resident did not experience any negative outcome. 2. Resident with dressings were assessed and medical records reviewed for valid orders. 3. In-services were provided for charge nurses on accuracy of dressing changes as ordered by the attending physician on 12/17/09, 12/18/09, 12/19/09 and 12/20/09. 4. Residents dressing changes will be monitored monthly by Resident Care Coordinators and reported through CQI quarterly. 5. Completion date 12/24/09.	

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L 052	Continued From page 7 Administration Record (TAR) revealed that Aquaphor ointment then 4X4/tape was initialed as being administered from September 12 through September 30, 2009. A review of the October 2009 TAR revealed that on October 5, 2009 the aforementioned order was discontinued/resolved. The November 2009 TAR indicated that the site: "® leg cleanse open area with NS, apply Aquaphor ointment daily then 4x4/tape daily until healed as DC ' d (discontinued)/resolved. " Although the order was discontinued as of October 5, 2009, Resident #7 was observed on November 5, 2009 with a white dressing on his/her right lower leg. A face-to-face interview was conducted with Employee #22 at the time of the observation. He/she stated, " The wound is completely healed. " A face-to-face interview was conducted at the time of the observation with Employee #7. He/she also indicated that the wound of Resident #7 is completely healed and identified a photo in the wound treatment book showing the wound completely healed. The record was reviewed on November 5, 2009. 3. A review of the clinical record for Resident #10 revealed that the charge nurse failed to act on a Nurse Practitioner ' s order for a gastroenterology (GI) consultation for a period greater than 2 months. An interim order signed by the nurse practitioner on August 21, 2009 directed " please make GI	L 052	Finding #3 – Resident #10 1. Resident's GI consult was discontinued on 12/18/09 by the nurse practitioner based on resident's condition and per request of resident and responsible party. 2. Other residents with orders for physician consult were reviewed and all resident consults had scheduled appointments. 3. Charge nurses were provided in-service on 12/17, 12/18, 12/19, 12/20, 12/22/09 on physician consult. 4. Physician consults will be monitored monthly through CQI. 5. Completion date 12/24/09.	

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L 052	Continued From page 8 appointment with [doctor ' s name] due to weight loss. " The record lacked evidence of a GI consultation. A face-to-face interview was conducted with Employee #5 on November 6, 2009 at approximately 3:00 PM. He/she acknowledged that the GI consultation was not done and stated that it would be scheduled. The record was reviewed November 6, 2009. 4. The charge nurse failed to follow the physician ' s order to monitor pain and obtain a Physical Therapy Consult and to prevent injury during transfer for Resident #16. A. A review of the physician ' s order signed by the physician on October 20, 2009 to " Monitor for pain every shift Y = Yes N = No. If pain is new, worsening or if pain [medication] med. was adjusted, changed - document on the pain assessment form. " A review of another physician ' s order dated September 18, 2009 revealed an order for " Acetaminophen 500mg caplet. Give one caplet by mouth three (3) times a day by mouth for pain. " Another physician ' s order dated October 26, 2009 was also noted. This order documented the following, " Oxycodone 5mg at 8PM every [q] day. " A review of the Medication Administration Record (MAR) revealed that the resident received Acetaminophen Caplets 500mg at 10:00AM, 2:00PM and 6:00PM daily on November 1, 2, 3, 4, 5, 6, 7, 8 and at 10AM on November 9, 2009. The MAR also revealed that the resident received Oxycodone daily at 8:00PM on November 1, 2, 3, 4, 5, 6, 7 and 8, 2009.	L 052	Finding #4 – Resident #16 1. Documentation on the MAR could not be changed or updated. Records of resident #16 was reviewed on 11/08/09, there were no negative outcomes noted. 2. All other residents on pain medication MAR's were reviewed to ensure that the residents were being monitored for pain and appropriate documentation existed. 3. Charge nurses received in-service on Pain Management/Monitoring and Documentation on 12/17/09, 12/18/09, 12/19, and 12/20/09. 4. Resident MARs will be reviewed for pain management assessment documentation monthly and reported to CQI quarterly. 5. Completion date 12/24/09	

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L 052	Continued From page 9 Further review of the MAR failed to reveal any documentation that the resident was monitored for pain as ordered by the physician. During a face-to-face interview conducted with Employee #8 at approximately 12:30PM on November 9, 2009 he/she acknowledged that there was no evidence that the resident ' s pain was monitored when the pain medication was administered. The record was reviewed on November 9, 2009. B. A review of the clinical record revealed that Resident #16 suffered a fall and sustained a fracture on September 13. According to documentation in the record, an X-ray report revealed a fractured right hip on September 14, 2009 and the resident was hospitalized at an area hospital later that evening. The resident returned to the facility on September 18, 2009. A physician ' s order dated September 18, 2009 documented " PT [Physical Therapy] eval. [evaluation] " Further review of the clinical record failed to reveal documentation of an evaluation from the physical therapist. A face-to-face interview was conducted with Employee #11 at approximately 11:30PM on November 9, 2009. He/she acknowledged that the PT Eval. was not done and added, " The Rehab. [Rehabilitation] department did not know he/she needed a PT Eval. I did not receive a consult. " Another face-to-face interview was conducted with Employee #8 at approximately 1:30PM on November 9, 2009. He/she acknowledged that the request for the PT Eval was never sent to the Rehab. Department. The record was reviewed on November 9, 2009.	L 052		

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L 052	Continued From page 10 C. Facility staff failed to safely transfer the resident to prevent accidents and/or injuries. Residents #16, The findings include: A review of Resident #16's record lacked evidence that the resident was safe for a two (2) `person transfer versus the use of an assistive device e.g. Hoyer Lift. During the process of a bed to chair transfer by two (2) Certified Nursing Assistants (CNAs) on September 13, 2009; the resident who was identified as dependent in transfer, subsequently was lowered to the floor and sustained a fracture of the right hip. A review of the quarterly Minimum Data Set (MDS) dated July 21, 2009 revealed a one (1) for Section B2a and b which indicated a problem with Short and Long Term Memory and two (2) for B4 which indicated a problem with Cognitive Skills for Daily Decision Making. A score of four (4) for Transfer and for Ambulation indicated that the resident was totally dependent on staff for both activities (transfer and ambulation). A score of two (2) in Section G4 indicated a loss of movement in both arms, hands, legs and feet. A weight of 193 pounds was recorded in Section K2 (Weight) of this MDS and a weight of 196 pounds on the significant change MDS dated September 29, 2009. Further review of the record revealed the following documentation which was dated September 13, 2009 at 8:30 AM; " Resident observed on floor in sitting position with her back	L 052	Resident #16 1. Residents was reassessed for alternative safe transfer method on11/16/09 and care plans were updated on 11/16/09. 2. All other residents requiring assistance with transfer were assessed for alternate method and care plan updated where needed. 3. Nursing staff were provided in-service on Methods of Resident Transfer on 12/17/09, 12/18/09, 12/19/09, and 12/20/09. 4. Residents will be monitored monthly for safe transfers by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09.	

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L 052	Continued From page 11 against the wall. (2) CNAs present in room and reported resident attempted to stand and leaned forward before staff could prevent fall landing with her back against the wall in sitting position. " A review of the facility ' s policy #99I-004 and Titled Lifting and Transferring Residents revealed documentation which stated, " Mechanical lift procedures are used on any resident who is obese or deemed unsafe for a two person manual transfer." A review of the resident's record failed to reveal an assessment to determine how the resident should be transferred. Under the heading of Procedures in Item #5 of the same document, it is stated, "The designated method of lifting and transferring of a resident is indicated in Resident Plan of Care." A review of the plan of care failed to reveal any documentation regarding the method of lifting or transferring the resident. A face-to-face interview was conducted with Employee #24 at approximately 11:00AM on November 9, 2009. He/she stated, "I went in to assist with transferring [Resident ' s name] from bed to chair. We sat him/her up and attempted to transfer him/her. He/she tried to stand. He/she started falling so we lowered him/her to the floor. He/she had a new pillow [cushion] and they wanted to use it [the pillow] to try getting him/her out of bed without the Hoyer lift." The employee acknowledged transferring the resident weighing 193-196 pounds without the use of a Hoyer Lift or a Gait Belt. A face-to-face interview was conducted with Employee # 11 at approximately 11:45AM on November 9, 2009. He/she acknowledged that the Rehabilitation Department had provided a wedge cushion for the resident's chair after a	L 052		

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L 052	Continued From page 12 prior fall on August 13, 2009. Employee #11 stated, "I taught the staff to transfer the resident without a Hoyer Lift. I demonstrated transferring the resident with the use of a Gait Belt." Employee #11 also acknowledged telling the staff that the resident could be transferred without the Hoyer Lift. He/she added, "It can be done. I have done it." In a telephone interview conducted at approximately 2:30PM on November 23, 2009 Employee #8 was asked whether there was any documentation to inform staff of the procedure to be followed when transferring the resident and whether in-services had been provided to train staff about the procedures. Employee #8 responded that there was no documentation and added, "Everyone knows how to transfer. There is nothing different about how to transfer this resident. The in-services are held annually. The last in-service would have been this Summer." During a telephone interview at approximately 2:30 PM on November 23, 2009 Employees #3 and #8 acknowledged that the mode of transfer for any resident can change on any shift. "Sometimes we do not have enough Hoyer lifts." Both employees also stated that the CNAs has his/her own report sheet and that the mode of transfer for each resident is usually documented on the report sheet. A blank report sheet was received by this regulatory agency. When asked about the documentation on the report sheet, Employee #8 acknowledged that there was no documentation. He/she stated, "We do not keep the sheets. They are discarded at the end of each shift. " A telephone interview was also conducted with Employee #11 at approximately 2:30PM on November 23, 2009. The employee stated, "There was no reason for me to be involved in the	L 052		

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L 052	Continued From page 13 transfer of this resident. They [staff] do a two (2) person transfer with him/her. A two (2) person transfer is a nursing transfer." He/she added, "However, they [staff] can use any transfer that they want or a Hoyer Lift. " Employee #11 acknowledged demonstrating a bed to wheel chair transfer to the staff with the use of a gait belt, and that she had no supportive documentation to verify the content of his/her instructions and/or the list of participants. The nursing staff failed to provide documentation that the resident was ever assessed to determine an appropriate mode of transfer for him/her or that the staff was adequately trained to transfer the resident safely to prevent accidents and/or injuries. The resident sustained a fractured hip while being transferred from his/her bed to a wheel chair by two CNAs. The record was reviewed on November 9, 2009. 5. Nursing staff failed to safely transfer Resident #19 who subsequently fell during a transfer. A review of the quarterly MDS completed March 31, 2009 revealed, "In Section G [Physical Functioning and Structural Problems] the resident was coded as total dependence for bathing and transfer and requiring two person physical assistance. Section J Health Conditions: J4 Accidents was coded as Resident #19 having no falls in last 31-180 days. " A nursing progress note dated January 15, 2009 at 2:00 PM revealed, "At 1:30 PM it was report to staff that Resident was observed in a sitting position on the floor in his/his room. CNA stated 'He/she was trying to transfer him/her self from the wheel chair to bed when his/her leg gave out and fell.' Upon assessment Range of Motion	L 052	Finding #5 Resident #19 1. Residents was reassessed for alternative safe transfer method on11/16/09 and care plans were updated on 11/16/09. 2. All other residents requiring assistance with transfer were assessed for alternative safe methods of transfer and care plans updated where needed. 3. Nursing staff were provided in-service on Alternative Safe Methods of Transfer on 12/17/09, 12/18/09, 12/19/09, and 12/20/09. 4. Residents will be monitored monthly for safe transfers by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09.	

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L 052	Continued From page 14 (ROM) in both upper/lower. " A Plan of Care related to falls last updated June 9, 2009 revealed, " ...January 15, 2009, Status Post (S/P) fall due to staff poor judgment." The care plan "Interventions Section" revealed, " Two person assistance with baths, transfers ...Transfers with mechanical lift ... " Interventions dated January 15, 2009, "Encourage staff to call for assistance." Nursing staff failed to transfer the resident in accordance with the plan of care. Subsequently, the resident fell. No injury was observed and/or noted. A face-to-face interview was conducted with Employee #8 on November 6, 2009 at 4:40 PM. He/she acknowledged that staff used "poor judgment during transfer". The record was reviewed on November 6, 2009. 6. Nursing staff failed to transfer Resident #20 safely to prevent accidents. A review of Resident #20's record revealed that on November 3, 2009 the resident sustained a 2 centimeter (cm) by 0.5cm laceration to his/her right shin while he/she was being transferred from a geri-chair to bed by two (2) Certified Nursing Assistants (CNAs). A review of the admission Minimum Data Set (MDS) dated September 24, 2009 revealed a one (1) for Section B2a and b which indicated a problem with Short and Long Term Memory and a three (3) for Section B4 which indicated severe impairment with Cognitive Skills for Daily Decision Making. A score of (0) for E1 and E4	L 052	Finding #6 Resident #20 1. The attending physician was notified and orders were received for treatment of laceration on 11/3/09. The resident was reassessed for alternative safe transfer method on 11/16/09. 2. All other residents requiring assistance with transfer were assessed for alternative safe methods of transfer and care plans updated where needed. 3. Nursing staff were provided in-service on Assessments and Methods of Transferring Residents on 12/17, 12/18, 12/19, 12/20, and 12/21/09. 4. Residents will be monitored for safe transfer by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09.	

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L 052	Continued From page 15 indicated the resident had no problems with mood and/or psychosocial behavior. A score of 4/3 for Bed Mobility indicated that the resident was totally dependent on two (2) persons when being moved in or out of bed (transfer). A score of four (4) for Ga and b indicated total dependence for Ambulation on/off the unit. A score of (0) for G4 indicated no limitation in any extremity. A review of the documentation in the Facility Occurrence Report dated November 3, 2009 at 2:45PM documented that, "Resident dropped her right ® foot and it got caught in between the geri-chair where he/she sustained the cut." Further review of the facility's Occurrence Report revealed recommendation from a supervisor which stated, " CNA [Certified Nursing Assistant] to be more careful with transporting residents and check position of limbs frequently. A face-to-face interview was conducted with Employee #5 at approximately 12:30PM on November 6, 2009. He/she stated, "They (the staff) demonstrated to me how it occurred. While they were transferring the resident into the bed from the geri-chair he/she [the resident] started tossing his/her legs around. The right leg got caught between the chair and the leg rest and the resident sustained a small cut on his/her shin. " A face-to-face interview was conducted with Employee #23 at approximately 2:30PM. on November 6, 2009. He/she stated that he/she was assisting another CNA to transfer Resident #20 from a geri-chair to bed and just as they were about to pick the resident up he/she tossed his/her right leg and it got lodged between the seat and the leg rest. The leg started bleeding right away and we reported it to the charge nurse.	L 052		

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L 052	Continued From page 16 The nursing staff failed to transfer the resident safely to prevent accidents and/or injuries and the resident sustained a laceration on his/her shin. The record was reviewed on November6, 2009. 7. Facility staff failed to ensure that a resident that enters the facility without pressure sores does not develop pressure sores. Resident D1. The findings include: Resident D1 is a 97 year old admitted with a primary diagnosis of Dementia and a secondary diagnosis of Latent Neurosyphillis. According to the significant change MDS completed September 17, 2009, " Section B Cognitive Patterns B2: Memory coded Resident D1 as having short-term and long-term memory problems; B4: Cognitive Skills for Daily Decision-Making was coded as moderately impaired; Section G Physical Functioning and Structural Problems G1a: bed mobility as (4) total dependent and (2) one person physical assist; G1i: Toilet Use (4) total dependent and (2) one person physical assist; G1j: Personal Hygiene coded as (4) total dependent and (2) one person physical assist; Section H Continence in Last 14 Days H1a: Bowel coded as (4) incontinent; Bladder coded as (4) incontinent; Section M Skin Condition M1b: number of stage 2 ulcers as one (1); M2a Type of Ulcer as zero (0) pressure ulcer, stasis ulcer coded as zero (0). M3 History of Resolved Ulcers in last 90 days as no. According to the Plan of Care: original date September 3, 2009 (no time indicated) with	L 052	Finding #7 Resident #D1 1. The Nurse Practitioner and attending physician were notified and orders were received for treatment on 10/07/09. 2. All other residents were assessed using the Braden Scale to make sure, preventive measures are in place and treatment orders obtained if necessary. 3. Nursing staff were provided in-service on Prevention of Pressure Ulcers and Wound Care Management on 12/17/09, 12/18/09, 12/19/09 and 12/20/09. 4. Resident skin integrity /pressure ulcers will be monitored weekly by Resident Care Coordinators and reported quarterly through CQI. 5. Completion date 12/24/09.	

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L 052	Continued From page 17 problem/strengths indicates: " August 29, 2009 Blister Left arm resolved; October 7, 2009 sacral skin breakdown, October 8, 2009 left arm breakdown. " The progress notes revealed the following: A nurse practitioner progress note dated and signed October 7, 2009 at 2:00 PM indicated, " Skin warm, dry, un-stageable wound noted to the sacral area, measures about 2x2; circular; redness around wound, no drainage noted area warm to touch. " A nursing progress note dated and signed October 7, 2009 at 4:30 PM revealed, " Sacrum, stage 2 open area measures 5X5 cm. Order given for Accuzyme after cleaning with Normal Saline (NS) daily until resolved. " According to the "Skin Assessment Sheet" dated October 7, 2009 (no time indicated) revealed, "Sacrum, pressure, 5X5 cm length and width, gray/black in character, no drainage, treatment for Accuzyme, turn every 2 hours, out of bed in chair, air mattress/with pump, heel elbow protectors for pressure relieving devices." A physician's progress note dated October 8, 2009 dated 11:15 AM documented, "96 year old resident with sacral decubitus ulcer. Patient has history of UTI on Zosyn via PICC line. Sacral 4x4 soft eschar, edges intact, no drainage, non-tender stage 3. Stage 3 or 4 sacral ulcer with necrotic skin, soft, questionable ischemic fat/subcutaneous, hypoalbuminemia, poor candidate for healing." Nursing progress note dated October 8, 2009 12:35 PM..."Abnormal lab results read to nurse	L 052		

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L 052	Continued From page 18 practitioner, [WBC][White Blood Cells] 19.3, [RBC] [Red Blood Cells] 3.68, hemoglobin 11.4, hct [hemaocrit] 34.7, sodium 160, potassium 3.4, glucose 159 mg/dl... According to the nurse practitioner noted dated October 30, 2009 at 10:00 AM, revealed "...Anemia-of chronic disease, Labs H/H [hemoglobin/hemaocrit] 8.0/24.0, started on FeS04 [Ferrous Sulfate], will monitor... 2. low albumin-ALB 1.5, due to compromised nutritional status..." The record lacked evidence that the residents sacral wound was identified prior to October 7, 2009 when it was identified as un-stageable by the nurse practitioner. A face-to-face interview was conducted with Employee #7 on November 6, 2009 at 2:30 PM. He/she acknowledged that there were no notes concerning skin breakdown of the sacral area in the record prior to the discovery of an ulcer on October 7, 2009.	L 052	Medical Wastes: 1. The infectious waste boxes were immediately turned right side up on 11/09/09 2. There were no other improperly stored medical waste boxes. 3. EMS director provided in-service to EMS staff 12/16/09. EMS director/designee will make daily rounds to check proper storage of infectious medical waste in closet. 4. EMS will monitor storage of infectious waste and report to CQI quarterly. 5. Completion date 12/16/09.	
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on the following observations made during an environmental survey conducted on November 4, 2009, it was determined that the nursing staff failed to store infectious waste boxes under sanitary conditions. Additionally, during a dining observation for Resident #14 on	L 091		

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L 091	Continued From page 19 November 5, 2009 at the lunchtime meal, it was determined that nursing staff failed to ensure proper food handling practices while feeding a resident. The findings include: 1. Four (4) of six (6) infectious waste boxes were stored upside down in the infectious waste storage room located in the basement. 2. Nursing staff failed to ensure proper food handling practices while assisting Resident #14 with nutritional intake. The Food and Drug Administration's (FDA) Employee Health and Personal Hygiene Handbook 2006 stipulates, "The 2005 FDA Food Code discourages bare hand contact with ready to eat food and requires the use of suitable utensils such as scoops, spoons, forks, spatulas, tongs, deli tissue, single-use gloves or dispensing equipment when handling these food items." During a dining observation on November 5, 2009 at approximately 12:35 PM Employee #22 was observed feeding Resident #14 with bare hands. The employee was observed placing potato tots and a submarine style sandwich into the resident ' s mouth with bare hands. A face-to-face interview was conducted with Employee #8 on November 5, 2009 at approximately 12:50 PM. In response to a query regarding the facility ' s protocol for handling food for residents that required feeding assistance, he/she stated that utensils should be utilized. If finger foods were administered, gloves should be worn.	L 091		

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L 091	Continued From page 20 Nursing staff failed to ensure the proper handling of food while feeding a resident.	L 091	Finding #1 1. Identified soiled muffin pans were removed from service immediately on 11/9/09. 2. All other muffin pans were checked for grease and washed if needed. 3. Staff were provided an in-service on 11/16/09 regarding proper cleaning procedures and the importance of keeping clean equipment. 4. The Dietary Director/designee will conduct weekly checks of cleaning assignment and inspect muffin pans. Observations will be reported to CQI quarterly. 5. Completion date 11/16/09. Finding #2 1. The identified soiled frying pan was immediately removed and discarded. New frying pans were purchased. 2. All other frying pans were inspected. There were no other soiled pans. 3. Staff were provided an in-service on 11/16/09 regarding proper cleaning procedures and the importance of keeping clean equipment. 4. Dietary management team will spot check daily to make sure all cooking equipment is clean and in good working order. 5. Completion date 11/16/09	
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 that were made during a survey of the dietary services on November 3 and 4, 2009 it was determined that the dietary staff failed to store, prepare or serve food under sanitary conditions as evidence by: 10 of 10 soiled muffin pans, four (4) of four stained frying pans, 16 of 64 damaged serving trays, and soiled stove burners and a convection oven. These observations were made in the presence of Employee #25 who acknowledged these findings at the time of the observations. The findings include: 1. 10 of 10 muffin trays were observed to be soiled with grease. 2. Four (4) of four (4) frying pans were observed to be covered with dark stains and needed to be cleaned or replaced. 3. 16 of 64 serving trays were observed to be damaged 4. One (1) of two (2) convection ovens and six (6) of six (6) stove burners were soiled with leftover food residue.	L 099		

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L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on review of records, it was determined that for three (3) of seven (7) " Individual Resident ' s Controlled Substances Records " discontinued controlled substance medications were not disposed of (or witnessed by) by two (2) licensed health care providers. On November 5, 2009 destruction of Discontinued Controlled Substances records were reviewed. The following discontinued controlled substances	L 128	L 099 continued Finding #3 1. Identified serving trays were immediately removed and discarded 11/6/09. 2. All other trays were checked for damage and discarded if damaged. 3. New trays were purchased. All staff were provided in-service on removing damaged equipment from service on 11/16/09. 4. The management team will spot check equipment used for residents weekly and report to CQI quarterly. 5. Completion date 11/16/09 Finding #4 1. The oven and stove were immediately cleaned on 11/6/09. 2. There were no other ovens to be cleaned. 3. Staff was provided an in-service on 11/16/09 regarding proper cleaning procedures and the importance of keeping clean equipment. 4. The management team will spot check equipment and report to CQI quarterly. 5. Completion date 11/16/09	

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L 128	Continued From page 22 lacked a witness as evidenced by the lack of a second signature: 1. Resident JKG3: Lorazepam 1mg, 27 tablets, disposition date September 1, 2009. 2. Resident JKG4: Oxycodone/APAP 7.5/325mg, 10 tablets, disposition date November 1, 2009. 3. Resident JKG5: Lorazepam 0.5mg, 13 tablets, disposition date October 1, 2009	L 128	L 128 Residents JKG3, JKG4 an JKG5 1. Documentation on Controlled Substance Record and the Medication Administration Record could not be changed or updated. Records of JKG1 and JKG2 were reviewed on 11/8/09; there were no negative outcomes noted on these residents. 2. All controlled substances records were reviewed and validated with MARs. No other findings were noted. 3. In-service was provided for licensed staff on Controlled Substance Medication/Documentation on 12/18, 12/19 and 12/20/09. 4. Controlled Substance and Medication Administration Documentation will be monitored by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09.	
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation, in the presence of facility staff, it was determined staff failed to remove expired medications found in the facility's Interim Box. On November 5, 2009, at approximately 2: 00 PM during the inspection of the facility's Interim Box, the following expired medications were found: 1. Four of four (4) ampules of Cogentin 1mg/1cc, expiration date September 2009 2. One of ten (10) vials Heparin 5,000units, expiration date October 2009 3. Two if four (4) Tobramycin 80mg/2cc, expiration date October 2009 4. Ten of ten (10) Dicloxicillin 250mg capsule, expiration date September 30, 2009 5. Ten of ten (10) Docusate 100mg capsules, expiration date September 2009	L 161	L 206 1. The Interim Box was replaced via STAT delivery on 11/5/09. There were no negative outcomes. 2. There are no other Interim boxes in the facility. 3. The Interim Box will be replaced twice a week by contract Pharmacy. 4. Interim Box will be audited by the pharmacist on a monthly basis and reported to CQI quarterly. 5. Completion date 11/5/09	
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of	L 206		

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 _____	11/09/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 23 occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on review of the occurrence reports and staff interview for 12 of 13 occurrences, it was determined that facility staff failed to consistently report the occurrences to the state agency. The findings include: Title 22 District of Columbia Municipal Regulations 3232.4 stipulates, "Each incident shall be documented in the resident ' s record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence." The "September 2009 Occurrence Report" line listing revealed 13 occurrences. At the time of the review, facility staff presented one (1) occurrence report with verification that the occurrence was sent to the state agency. A face-to-face interview was conducted with Employee #3 on November 6, 2009 at 3:00 PM. He/she acknowledged that of the all of the occurrences had been reported but was only able to produce documentation that one (1) was reported to the state agency.	L 206	1. Identified occurrence report of 11/6/09 was re-faxed to the Department of Health on 12/24/09. 2. All other occurrence reports were reviewed to ensure that all appropriate occurrence reports were faxed to the Department of Health with confirmation fax sheet. 3. The Operations Coordinator will be responsible effective 12/23/09 for sending, tracking and validating distribution reports to the Department of Health. A log will be maintained in Administration. Nursing leadership provided training on revised process on 12/22/09. 4. Occurrence Reporting will be monitored monthly through CQI. 5. Completion date 12/24/09	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and	L 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 214	Continued From page 24 supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: B. The nursing staff failed to ensure that the residents' environment remained as free of accident hazards as is possible as evidenced by failing to secure oxygen tanks. On November 5, 2009 at 9:40 AM five (5) full oxygen tanks were observed unsecured in the oxygen tank storage room in the basement of the facility. Eight (8) of eight (8) empty oxygen tanks were also found unsecured at that time.	L 214	1. Five (5) full oxygen tanks and eight (8) empty oxygen tanks were secured properly on 11/05/09. 2. All medical and other equipment in the facility was checked for safe storage. 3. Nursing staff and other employees were provided in-service on Safe Storage of Equipment and Accident Prevention on 12/17, 12/18, 12/19, and 12/20. 4. Safe storage of equipment will be monitored monthly through CQI. 5. Completion date 12/24/09.	