DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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<br><br>A recertification and complaint investigation(s) survey was conducted on April 20 through 28, 2009. The following deficiencies were based on observations, record review, and staff and resident interviews. The sample included 30 residents based on a census of 225 residents on the first day of survey and 12 supplemental residents. | F 000 | JB Johnson Nursing Center makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Law. | |
| F 157 SS=D | 483.10(b)(11) NOTIFICATION OF CHANGES<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update | F 157 | 1. The physician and/or responsible parties of Residents #6, #16, and F1 were notified regarding their condition, unable to retrospectively correct the date /time they were notified.<br><br>2. A review of residents with weight loss, changes in conditions of skin and those with x-rays taken within the last 6 months was done. No other residents were affected by this practice.<br><br>3. An in-service was conducted with licensed staff regarding notification requirements, including notification of physician, legal representative or interested family member.<br><br>4. The comprehensive medical record audit addresses physician/ family notification. This tool is completed monthly, and results are presented quarterly to the QA Committee | 6/25/09 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN1-PhD (Dr. Sikirat Disu) TITLE: Administrator (X6) DATE: 6/19/09

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 157 | Continued From page 1 | F 157 | | |

the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews for two (2) of 30 sampled residents and one (1) of 12 supplemental residents, it was determined that facility staff failed to notify the physician of: one (1) resident's weight loss; one (1) resident's left ankle pressure ulcer and one (1) resident's family of positive findings of a breast exam. Residents #6, 16, and F1.

The findings include:

1. Facility staff failed to notify the attending physician of Resident #6's weight loss in a timely manner.

A review of the resident's clinical record revealed that the dietician documented in the Interdisciplinary Care Plan on January 22, 2009, "Wt. [weight]. 118 [to] 100 [pounds] x 1mo [one month]. ST [Speech Therapist] consult. WW [weekly weight] x 4 [for four weeks.]"

On February 23, 2009 the dietician documented, "Wt loss continues despite intervention. ST working with [him/her]. Wt 98 [pounds]."

Review of the dietary notes, nurses' notes and physician's progress notes in the clinical record for January and February 2009 lacked evidence that the physician had been notified of the resident's continued weight loss.

A physician's order dated and signed on March 9,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 157 | Continued From page 2 | F 157 | | |

2009, directed, "Family conference to discuss weight loss and plans."

A face-to-face interviews were conducted with Employee #12 at approximately 11:10 AM on April 22, 2009 and Employee #27 at approximately 2:30 PM on April 22, 2009. Both employees acknowledged that the record lacked evidence that the physician was notified of the resident's weight loss prior to March 9, 2009. The record was reviewed on April 21, 2009.

2. Facility staff failed to notify the physician and the responsible party of a pressure ulcer on the left ankle of Resident #16.

A review of the resident's clinical record revealed the following nurses' notes:

March 30, 2009 at 7:00 AM "Resident noted with a re-open area on the Lt. (Left) malleolus. Resident scratches area. Finger nails trimmed short, re-open area was cleansed with NSS (Normal Saline Solution), pat dry, applied Neosporin, a 4 x 4 taped until seen by wound doctor."

April 3, 2009 at 11:00 PM: "Resident was noted with left ankle open area this shift. MD (Medical doctor) was made aware and treatment order was given until further evaluation by wound team. RP was also notified. Ankle wound measures 1.2 cm x 1 cm."

A further review of the resident's record: the nurse's notes lacked evidence that the facility staff immediately informed the physician and the RP that the resident was observed with a left ankle pressure ulcer.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 157 | Continued From page 3<br><br>A face-to-face interview was conducted with Employee #28 on April 27, 2009 at approximately 10:20 AM. After reviewing the resident's clinical record, Employee # 28 acknowledged the aforementioned findings. The record was reviewed on April 27, 2009.<br><br>3. Facility staff failed to notify the responsible party of a positive finding to the left breast for Resident F1.<br><br>A review of a radiology report dated December 3, 2007 revealed, " ...Diagnosis: Routine GYN Exam, Examination: Mammogram Bilat diag [bilateral diagnostic] ... Impression: Clinical History: Left breast mass ...Examination of the left breast shows an area of density in the lower-inner quadrant. This area is suspicious and biopsy is recommended. A sonogram was performed on this patient and a sonographic report is to follow. The mass mammographically and sonographically is suspicious and biopsy is recommended."<br><br>A review of the physician's note dated December 12, 2007 lacked evidence that the physician reviewed the positive findings to the left breast.<br><br>A review of Resident F1' s Physical Examination form dated and signed by the physician February 20, 2008 revealed, " ...Chest/Breast: left breast mass ..."<br><br>A review of the physician's order written signed and dated July 25, 2008 revealed, "Please make an appointment with interventional radiology ... at | F 157 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 157 | Continued From page 4<br>[name of hospital] for breast biopsy (left breast) ASAP."<br><br>A review of the nursing notes dated September 10, 2008 at 4 PM revealed, "Resident left the unit to Cancer Institute for breast biopsy at [hospital] (left breast). Procedure not done rescheduled for September 17, 2008 at 10:30 AM ..."<br><br>September 16, 2008 at 3:00 PM ..." Resident's responsible party made aware of resident appointment at [hospital] on September 17, 2008 for breast biopsy ..."<br><br>A review of the physician and nursing notes lacked evidence that the family was notified of the positive findings to the left breast from December 12, 2007 to September 16, 2008.<br><br>A face-to-face interview was conducted on April 23, 2009 at 1:30 PM with Employee #26. He/she acknowledged that the family was not notified until September 17, 2008. The record was reviewed on April 23, 2009. | F 157 | | |
| F 164 SS=D | 483.10(e), 483.75(l) (4) PRIVACY AND CONFIDENTIALITY<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e) (3) of this | F 164 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 164 | Continued From page 5<br>section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview, for two (2) of 12 supplemental residents, it was determined that facility staff failed to provide personal privacy for: one (1) resident during shower and one (1) resident inadequately draped after shower. Residents A2 and A3.<br><br>The findings include:<br>1. Facility staff failed to provide adequate draping after a shower for Resident A2.<br>During the initial tour of the facility, Resident A2 was observed on April 20, 2009 at approximately 10:15 AM coming out of the "Spa" room on 3 South wearing a robe. The resident's buttocks were visible-not completely covered by the robe. The resident was accompanied by Employee #16. Employee #17 witnessed the resident in the company of Employee #16.<br>Facility staff failed to provide adequate draping | F 164 | 1. Residents #A2 and A3 were immediately provided privacy.<br><br>2. A review of the units were conducted during "shower times". No other residents were noted to be affected.<br><br>3. The nursing staff will be re-educated regarding resident's rights including privacy.<br><br>4. Monitoring of privacy is done monthly by the clinical staff. The report of these audits will be presented at the quarterly QA Committee meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 164 | Continued From page 6<br>after shower for Resident #A2.<br>A face-to-face interview was conducted with Employee #16 on April 20, 2009 at approximately 10:20 AM. He/she acknowledged that the resident was inadequately draped with the robe he/she was wearing.<br><br>2. Facility staff failed to provide privacy to Resident A3 during a shower.<br>Resident A3 was observed during a tour of the facility on, April 20, 2009 at approximately 4:00 PM showering. The resident's entire body was exposed and visible to people who were not involved in the provision of the resident's personal hygiene administration. The shower room / spa door was not closed and the privacy curtain was not completely pulled to provide the resident with complete privacy during shower.<br>A face-to-face interview was conducted with Employee #18 on April 20, 2009 at approximately 4:05 PM. He/she acknowledged that the door to the shower room was not closed and the privacy curtain was not completely pulled to provide the resident with complete privacy during shower. He/she acknowledged unnecessarily exposing the resident's unclothed body. The record was reviewed April 20, 2009. | F 164 | | |
| F 167 SS=C | 483.10(g) (1) EXAMINATION OF SURVEY RESULTS<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. | F 167 | 1. The results of the most recent survey is located at the receptionist desk in a three ring binder. This desk is at wheelchair level. Signs have been placed on all units to inform residents of its location.<br><br>2. Signs indicating where the federal/state survey is located has been posted on all units.<br><br>3. The staff were re-educated regarding resident rights including posting of survey.<br><br>4. Posting of contact information is a part of the Administrative audit tool. This information is presented at the QA committee meeting bi-annually. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 167 | Continued From page 7<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, it was determined that facility staff failed to make the survey results readily accessible to residents and to post a notice of their availability.<br><br>The findings include:<br><br>Observations made by the survey team on April 20 and 27, 2009 on eight (8) of eight (8) units, the facility failed to post signage indicating the location of survey results; and the survey book was observed secured to the receptionist ' s desk located in the main lobby of the facility. | F 167 | | |
| F 225 SS=D | 483.13(c) (1) (ii)-(iii), (c) (2) - (4) STAFF TREATMENT OF RESIDENTS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law | F 225 | 1. On April 3 when it was determined that resident #SM1 was not on his unit, a detailed search was conducted and after determining resident was not in the facility the search expanded to surrounding perimeter and external environment. The physician, all agencies, and family were notified. Though resident was not located initially staff continued to search until resident was located and returned to the facility. No injury or harm was noted.<br><br>2. A review of the investigative protocol was completed. Key staff members involved were re-educated. No other resident was found to be affected by this practice. A review of all residents with a risk of elopement was conducted. No other resident was found to be affected by this practice.<br><br>3. Nursing staff were re-educated on the Elopement Policy. Security cameras were increased from twenty- two to thirty. One camera was installed at a ninety degree angle on the opposite door to the door where the resident eloped.<br><br>4. The investigation form has been modified. A review of the investigations is a part of the Monthly QA program and will be included in the QA Committee meeting quarterly. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 225 | Continued From page 8<br>through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 12 supplemental sampled residents, it was determined that facility staff failed to completely investigate the elopement of Resident SM1 from the facility.<br><br>The findings include:<br><br>A review of the facility's "Resident Abuse Policy" last revised April 7, 2006 revealed, "...5. Investigate all incidents within 24 hours. Include interviews and observations."<br><br>The resident was noted to be missing from the facility on April 3, 2009. A review of the "Incident Analysis" dated Friday April 3, 2009 revealed, "...there were visitors in the facility, including 3 South. The resident with [his/her] alarm band was able to exit the unit when the visitors went | F 225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING<br>B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 225 | Continued From page 9 | F 225 | | |

Continued From page 9

through the secured door at noon [on] Friday, April 3... [it] was also a banking day for all residents; therefore there was a lot of activities on the basement level form where the resident eloped. At 12:15 PM, the door alarm system went off, necessitating the facility to be placed on "Elopement Status"..."

A face-to-face interview was conducted on April 27, 2009 at 4:25 PM with Employee #12. He/she stated, "Resident SM1 goes down to smoke in the courtyard. An aide took him/her out. He/she did not elope from up here [3 South], he/she eloped from the courtyard. [He/she] was escorted down to the courtyard to smoke and he/she never returned to the unit. This was around 12:00 PM on that Friday [April 3, 2009]."

A face-to-face interview was conducted on April 27, 2009 at approximately 5:00 PM with Employee #37. He/she stated, "I was monitoring the courtyard at 12:00 PM. When you are monitoring the courtyard you have to keep an eye on who comes in and out. I know who wanders and elopes. Resident SM1 never came to the courtyard. I never saw him/her. I was sitting in the gazebo. I never saw him/her smoke. I don't remember the resident leaving the courtyard. I didn't see him/her in the courtyard."

Face-to-face interviews were conducted on April 27, 2009 at 6:30 PM with Employees #1 and 2. Employee #2 stated, "Resident SM1 elope from courtyard. We just found out about an hour ago. We didn't know this information before." Employee #1 stated, "The investigation was completed. He/she came down to smoke. His/her family member brings him/her cigarettes. He/she left the building through this door."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 225 | Continued From page 10<br><br>When queried if interviews were conducted with the CNA assigned to the resident and any additional staff, Employee #1 replied, "We conducted the investigation. We just found out about the resident leaving from the courtyard."<br><br>A follow up face-to-face interview was conducted on April 27, 2009 at 6:40 PM with Employee #12. He/she stated, "Resident SM1 goes down to smoke in the courtyard. An aide took him/her out but he/she usually comes back on his/her own. In the process of coming back to the unit from smoking, he/she went to the basement and eloped through the basement door in the Ruby Room. The alarm went off. At that time, we did a census count for all residents in the building and realized that [Resident SM1] was not in the building."<br><br>The investigation lacked evidence that the information provided by staff members regarding this incident was consistent with the investigative report. Additionally, there was no evidence that the above cited staff was interviewed during the facility's investigation. | F 225 | | |
| F 241<br>SS=D | 483.15(a) DIGNITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations and staff interview for one (1) of 30 sampled resident and two (2) of 12 supplemental residents, it was determined that | F 241 | 1. Resident #16 was immediately provided with a clean splint. Resident #A1 frequently disrobes self and redresses himself with multiple layers of clothing including his over-coat. He believes this is appropriate due to his previous occupation. He was immediately assisted with grooming and coat was removed only for him to redress himself again with the coat this is part of his behavior "ritual" Resident # S1 was dressed immediately and staff was reminded to write on tape prior to placing on residents dressing. Unable to retrospectively correct. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 241 | Continued From page 11<br>facility staff failed to promote residents 'dignity as evidenced by: one (1) resident with a soiled splint, one (1) resident wearing soiled clothes, and one (1) resident who was sitting in his/her room in underwear and tee shirt visible from the hallway and during a wound change observation, the nurse wrote on the tape when it was on the resident's foot. Residents #16, A1 and S1.<br><br>The findings include:<br><br>1. Facility staff failed to ensure that Resident #16 had a clean splint.<br><br>Resident #16 was observed during a wound care treatment in his/her room. The resident was wearing a soiled hand splint on the right hand.<br><br>A face-to-face interview was conducted with Employee #28 on April 27, 2009 at approximately 10:10 AM. After an inspection of the hand splint, he/she acknowledged that the resident's hand splint was soiled.<br><br>2. Facility staff failed to ensure that Resident A1 was dressed in clean clothes and in clothes appropriate for the weather.<br><br>During the initial tour of the unit on April 20, 2009 at approximately 10:00 AM, Resident A1 was observed in his/her bed wearing multiple layers of malodorous soiled clothing including a winter coat soiled with food debris. The layers of clothing and top coat he/she was wearing were malodorous and soiled with food. Also on the resident's bed was a pile of his / her clothing.<br><br>On April 21, 2009 at approximately 11:00 AM the resident was observed in his/her room, wearing | F 241 | 2. A review of the residents clothing and appearance was conducted. No other resident was found to be affected by this practice. A review of staff completing treatments was done and no other residents was affected by this practice.<br><br>3. Staff were re-educated regarding residents rights. Dignity was included in the training.<br><br>4. Monitoring of the residents as it pertains to privacy and dignity is conducted monthly by the Nursing Staff. This information is presented at the quarterly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ________ B. WING ________ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 241 | Continued From page 12 | F 241 | | |

multiple layers of malodorous soiled clothes: several shirts and pants and the same winter coat worn the previous day.

The resident was observed in bed on April 27, 2009 at approximately 9:40 AM. He/she was wearing multiple layers of malodorous soiled clothes.

According to Section I (Disease Diagnoses) in the annual Minimum Data Set (MDS) complete on March 4, 2009, the resident's diagnosis included Alzheimer's Disease, Delusion and unsteady gait. And according to Section G (Physical Functioning and Structural Problems), the resident required limited assistance with dressing and one person extensive assistance with personal hygiene.

Facility staff failed to ensure that Resident A1 was dressed in clean clothes and in clothes appropriate for the weather.

A face-to-face interview was conducted with Employee #17 on April 27, 2009 at approximately 9:45 AM. He/she acknowledged the aforementioned findings. He/she said, "He liked dressings in layers and the plan was to keep only one set of clothing within his / her reach."

3. Facility staff failed to promote Resident S1's dignity who was observed sitting in his/her room in underwear and a tee shirt visible from the hallway. Additionally, during a wound change observation, the nurse wrote on the tape on the resident's foot.

An observation and interview was conducted on April 24, 2009 at 10:50 AM with Resident S1. The resident was seated in a chair opposite the door,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 241 | Continued From page 13<br>wearing a tee shirt and underwear (disposable). The door was open and he/she was in full view from the hallway. Upon inquiry, the resident stated that he/she had completed breakfast and that the nurse had removed the tray. When asked if he/she required assistance for dressing, Resident S1 stated, "I can dress myself. Usually the curtain is pulled. I guess (employee) forgot when [he/she] picked up my tray. I am waiting for the nurse to fix my foot."<br><br>Employee #20 entered the room to complete a wound treatment. The resident was putting on his/her shirt while walking from the chair to the bed. The resident tucked the tails of the shirt under his/her groin. Employee #20 pulled the privacy curtain and completed the wound treatment. Employee #20 removed a pen from his/her pocket and dated, timed and initialed the tape on the wound dressing on the resident's foot.<br><br>After the wound treatment was completed, Employee #20 pushed the curtain back and stated to the resident, "You want to finish dressing now?" The resident responded, "Yes" and got up from the bed and sat in the same chair opposite the open door. Employee #20 left the resident ' s room with the door open and the privacy curtain pushed to the side allowing full exposure of the resident from the hallway. | F 241 | | |
| F 247<br>SS=D | 483.15(e) (2) NOTICE BEFORE ROOM CHANGE<br><br>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.<br><br>This REQUIREMENT is not met as evidenced by: | F 247 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 247 | Continued From page 14<br>Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to give Resident #5 notice and relocation destination (7) days prior to room relocation within the facility.<br><br>The findings include:<br><br>A review of the " Notice of Discharge or Transfer from a Nursing Facility or Relocation within a Nursing Facility " dated April 3, 2009 revealed, " Required Contents: ...3. You are scheduled to be relocated on or by April 3, 2009. 4. Your destination is to be determined. "<br><br>A nurse's note dated April 3, 2009 at 3PM [3:00 PM] revealed, "Resident has been transferred from 3N, room 303A to 3S, room 312B ... RP [responsible party] [name] notified ...MD notified ..."<br><br>The record lacked evidence that Resident #5 was given notice and destination relocation seven (7) days prior to relocating him/her within the facility.<br><br>A face-to-face interview was conducted on April 21, 2009 at approximately 1:30 AM with Employee #25. He/she acknowledged that the resident was relocated and destination was not given seven (7) days prior. The record was reviewed on April 21, 2009. | F 247 | | |
| F 248 SS=D | 483.15(f) (1) ACTIVITIES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. | F 248 | 1. The Nursing staff on 1 South were re-in-serviced on using the activity resource book. Unable to address the residents as information was not included in resident sample.<br><br>2. All units were checked to ensure unit activities were conducted<br><br>3. The Nursing staff will be re-educated regarding recreation activity program including the activity resource book during new employee orientation and periodically throughout the year.<br><br>4. Monthly monitoring of activities is a part of the QA program. Outcome will be presented at the QA Committee meeting | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 248 | Continued From page 15<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and staff interview, it was determined that facility staff failed to ensure that all aspects of the facility's activity program were implemented.<br><br>The findings include:<br><br>Four (4) residents were observed on Unit 1 South on April 20, 2009 at 10:00 AM and 12:00 PM, sitting in wheel chairs against the wall across from the clean and soiled utility rooms.<br><br>This observation initiated an investigation of the activates program.<br><br>A face-to-face interview with Employee #23 was conducted on April 22, 2009 at 2:10 PM. He/she stated, "We have large activities for the whole house. We have unit activities everyday. We have volunteers who do the one-on-one programs. Right now we have one activity aide on every floor. We have developed a book for the CNAs (certified nurse aide) to use while they are in the day rooms between unit and group activities with the residents.<br><br>Our residents like word games and trivia games. The book has all kinds of things to do like word games, trivia, and songs. The aides (CNAs) have been in-serviced on using these books."<br><br>Facility staff received in-service/training regarding unit-based activities wherein they were informed regarding the content, use and location of the Unit Activity Book. The training was conducted by Employee #23, offered facility-wide and covered | F 248 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 248 | Continued From page 16 | F 248 | | |

each shift. According to a review of the facility's in-service manual, the training dates were October 6 through 14, 2008, November 11, 2008, February 10, March 10 and 31, and April 14, 2009.

A face-to-face interview was conducted on April 24, 2009 at 9:45 AM, with Employee # 37. He/she stated, " CNAs are supposed to do activities with residents when Rec Therapy (Recreation Therapy) is not around. There is an activity book on the unit."

A face-to-face interview was conducted with Employee #8 on April 24, 2009 at 10:10 AM. He/she stated, " The CNA in the day room is there to stop residents from getting into fights."

A face-to-face interview was conducted with Employee #40 on April 24, 2009 at 2:00 PM on Unit 1N. When queried about duties of the CNA in the day room, he/she stated, " I am just supposed to watch them."

A face-to-face interview was conducted with Employee #39 on April 24, 2009 at 2:05 PM. In response to a query about the location of the Activity Book, Employee #39 found the book on the shelf above the nurse' s station sink and placed it on the nurse' s station desk. The book remained on the desk until the residents were escorted to a formal activity off the unit at 2:25 PM.

The CNA assigned to the day room on Unit 1 South failed to follow the designed activities program and the unit activity manual was not readily available for staff use.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW, WASHINGTON, DC 20001 |

| (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 248 | Continued From page 17<br>A face-to-face interview was conducted with Employee #2 on April 27, 2009 at 4:45 PM. He/she stated, " It is expected that all the CNAs who monitor the residents in the day room will use the activity book."<br><br>Facility staff lacked evidence that they consistently implement the activity program as designed by the facility's Recreational Therapy Department. | F 248 | | |
| F 250 SS=D | 483.15(g)(1) SOCIAL SERVICES<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to provide medically- related social services for Resident #13.<br><br>The findings include:<br><br>A review of Resident #13's record revealed a consulting behavioral therapist' s report that was conducted on February 19, 2009. "Recommendations" written included," Continue individual counseling to help with sadness and frustration as well as maintain mental status. 2. Day program or activity outside the facility."<br><br>Social worker progress notes for February 19 and April 23, 2009 were reviewed. There was no | F 250 | 1. A meeting was conducted with the mental health counselor and the recommendation made by the therapist was individual counseling. Interdisciplinary meeting has been scheduled to review recommendation.<br><br>2. The Social Work staff reviewed the psychiatric (mental health) section to ensure the recommendations are reviewed and in compliance.<br><br>3. The mental health provider were contacted including the Mental Health Counselor and Psychiatrist and are required to provide a monthly report to the Social Service Department. Social Services will review recommendation monthly.<br><br>4. The monthly review of reports recommendation of the mental health consultants will be provided to the quarterly QA committee | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 250 | Continued From page 18<br>evidence that the social worker had followed up on the above cited recommendation.<br><br>A face-to-face interview was conducted with Employees #4 and 25 on April 23, 2009 at 11:30 AM. When queried regarding the behavioral therapist' s recommendation, Employee #4 stated," I really didn't even know about this recommendation. I would have talked to the doctor and if [he/she] agreed, then I would have found a program for [the resident]. The psychiatrist comes on Saturday and the behavioral therapist comes in whenever. Neither of them leaves a list of residents that they have seen. We don' t have a system to ensure that social services are made aware of the consults."<br><br>Employees #4 and 25 acknowledged that there was no system in place to notify the social workers to ensure that medically related-social services were provided to residents as a result of the psychiatrist and/or behavioral therapist visits. The record was reviewed April 23, 2009. | F 250 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation during the environmental tour of the of the facility conducted on April 20, 2009 from 12:30 PM through 4:30 PM and April 21, 2009 from 8:30 AM through 12:45 PM, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary | F 253 | 1. All areas cited during the survey have been cleaned, repaired and/or replaced<br><br>2. An environmental survey of the facility was conducted. A schedule has been conducted to correct any concerns identified.<br><br>3. The Director of Environmental Services will re-educate staff regarding the responsibilities of the department . The preventative maintenance program was reviewed and/ or updated to monitor and inspect the center. The Engineering/Maintenance Department has been re-educated on this. The Beautician/ Barber and Rehab Manager have been re-instructed to monitor/report concerns in their respective areas, and maintain a clean environment.<br><br>4. A Team has been developed to inspect daily a different section of the facility. The findings of this environmental rounds are corrected immediately and reported to QA. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 253 | Continued From page 19 | F 253 | | |

manner as evidenced by:

Soiled: 11 of 52 resident room window sills, 12 of 12 rubber runners, four (4) of 36 corners, eight (8) of eight (8) mechanical lifts, 16 of 16 standing and sitting scales, 10 of 50 shelves in residents ' rooms, nine (9) of 19 chairs in common areas, three (3) of three (3) resident wheelchairs, elevator tracks for three (3) of three (3) elevators and one (1) of one (1) exercise wheel in the Rehabilitation Department.

The following items were observed marred/damaged: four (4) of 50 wall guards, 21 of 86 walls, 16 of 72 floors, seven (7) of 86 baseboards and four (4) of 40 thresholds.

The following items were observed soiled and/or damaged in the Beauty Shop: floor, four (4) of four (4) combs, three (3) of three (3) brushes, four (4) of four (4) metal hot curlers, four (4) of four (4) drawers soiled with hair, and interior and exterior surfaces of three (3) of three (3) hair dryers.

These observations were made in the presence of Employees #21 and 22 who acknowledged the findings at the time of the observations.

The findings include:

A. The following items were observed soiled:

1. Window sills in rooms 101, 113, 200, 206, 211, 217, 218, 219, 300, 402 and 421 in 11 of 52 resident rooms observed.
2. Rubber runners in the dining rooms on 1S, 1N, 2S, 2N, 3S, 3N, 4S, and 4N and in the hallways between 1S and 1N, 2S and 2N and 3S and 3N

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 253 | Continued From page 20<br>and 4S and 4N in 12 of 12 rubber runners observed.<br>3. Corners in rooms 1N clean linen room, 2N dayroom, 3S bath room, and 4S dining room in four (4) of 36 rooms observed.<br>4. Mechanical lifts, sitting and standing scales on 1N, 1S, 2N, 2S, 3N, 3S, 4N and 4S in 24 of 24 scales and lifts observed.<br>5. Shelves in resident rooms: 200, 206, 211, 214, 217, 218, 228, 401, 419 and 433 in 10 of 50 resident rooms observed.<br>6. Chairs in resident common areas: three (3) of three (3) yellow plastic chairs on 2S, two (2) of eight (8) chairs in 2S dining room, one (1) of three (3) chairs in 2S day room, three (3) of five (5) chairs in the 3N dining room in nine (9) of 19 chairs observed.<br>7. Wheelchairs in rooms 219, 304, and outside of room 422 in three (3) of three (3) soiled wheelchairs observed.<br>8. Elevator tracks for two (2) of two (2) elevators on five (5) floors and one (1) of one (1) elevator for four (4) floors in three (3) of three (3) elevators observed.<br>9. One (1) of one (1) exercise wheel in the Rehabilitation Department.<br><br>B. The following items were observed marred/damaged:<br>1. Wall guards in resident rooms 101, 217, 316 and 419 in four (4) of 50 rooms observed.<br>2. Walls in rooms 1N linen room, 1S soiled utility room, 108, 118, 122, 2S soiled utility room, 2S dining room, 200, 309, 330, 324, 4S housekeeping room, 4S handicap toilet, 4S janitor closet, 4N dining room, 4N dayroom, 400, 404, 419, 421, and 426 in 21 of 86 walls observed.<br><br>3. Baseboards in rooms/areas 1N pantry, 1N | F 253 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 253 | Continued From page 21<br>dayroom, 208, hallway near 1S janitor room, 2N dayroom, 3N dayroom and 4S hallway in seven (7) of 86 areas observed.<br>4. Thresholds in 1S tub room, 2N pantry, 2S shower room, and 4S clean utility room in four (4) of 48 thresholds observed.<br><br>C. The following items were observed soiled and/or damaged in the Beauty Shop:<br>1. The floor in one (1) of one (1) floor observed.<br>2. Four (4) of four (4) combs observed.<br>3. Three (3) of three (3) brushes observed.<br>4. Four (4) of four (4) metal hot curlers observed.<br>5. Four (4) of four (4) drawers soiled with hair.<br>6. The interior and exterior surfaces of three (3) of three (3) hair dryers observed. | F 253 | | |
| F 276 SS=D | 483.20(c) QUARTERLY REVIEW ASSESSMENT<br><br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview of one (1) on 30 sampled residents, it was determined facility staff failed to complete a quarterly Minimum Data Set [MDS] assessment for Resident #3.<br><br>The findings include:<br><br>Resident #3 was admitted to the facility December 12, 2008. An admission MDS was completed December 23, 2008. There was no evidence that a quarterly MDS had been completed for March 2009. | F 276 | 1. The MDS was completed for Resident #3 on 5/9/09 and Transmitted 5/11/09.<br><br>2. All charts were reviewed to ensure that no other resident's quarterly assessment was missed. No other resident was affected by this isolated practice.<br><br>3. The clinical team was re-educated regarding the MDS as well as time frame for completion.<br><br>4. A review of the MDS is a part of the QA program. The MDS and present findings at the QA meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 276 | Continued From page 22<br><br>According to the " MDS User's Manual 2.0, Chapter 2, page 2-15, " ...92 days are measured from the date at MDS item R2b of one assessment to item R2b of the next assessment. "<br><br>A face-to-face interview was conducted with the MDS coordinator on April 24, 2009 at 10:00 AM. He/she stated the resident was receiving skilled services during the period of March 2009 and PPS (Prospective Payment System) assessments were completed and a quarterly MDS was not required.<br><br>According to the " MDS User's Manual 2.0, Chapter 2, page 2-36, " SNF providers are required to meet two assessment standards in a Medicare certified facility: The OBRA standards requiring comprehensive assessments on admission, annually, when a significant change in status occurs or when a significant correction of a prior full assessment is required. Quarterly assessment is also required on the form designated by the State ... "<br><br>There was no evidence that a quarterly MDS was completed in March 2009 92 days after the admission assessment. The record was reviewed April 24, 2009. | F 276 | | |
| F 278 SS=E | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 23<br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for 12 of 30 sampled resident record and one (1) of 12 supplemental residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) assessment for: three (3) residents for behaviors, four (4) residents for disease diagnoses, two (2) residents for pain, one (1) resident for weight loss, two (2) resident's pressure ulcer, four (4) residents for infections, one (1) resident for restorative nursing, and failed to sign the face sheet for one (1) resident. Residents #2, 4, 5, 7, 8, 10, 11, 16, 17, 18, 20, 28 and A1.<br><br>The findings include: | F 278 | 1. The residents and records for residents # 2,4,5,7,8,10,11,16,17,18,20,28 and A1, were checked. The MDS for residents 4, 5, 7, 8, 10, 11, 17, 18 and A1, has been modified. Residents #2, 16 and 20 will have corrections made on the next assessment. #28 is a closed record unable to retrospectively correct.<br><br>2. All residents charts due for scheduled assessment will be reviewed with the IDT Team to ensure that no other chart will be affected with this practice.<br><br>3. The MDS staff were re-educated on accurate Coding of the MDS. Additionally the number of RN's have increased to one RN per unit.<br><br>4. A review of the MDS is conducted monthly by the MDS Coordinator. The information is presented at the quarterly QA meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 24 | F 278 | | |

The Assessment Reference Date (ARD) is described in the "MDS 2.0 Use's Manual" on page 3-29 as, "This date refers to a specific end-point for a common observation period in the MDS assessment process."

1. The facility staff failed to accurately code Section E (Mood and Behavior Patterns) on Resident #2's quarterly MDS.

According to the quarterly MDS competed February 11, 2009, the resident was coded in Section E1 for persistent anger, and in Section E4 for resisting care and socially inappropriate/disruptive behavior. The ARD date was February 10, 2009. Section E1 has a 30 day look back period and Section E4 has a seven (7) day look back period.

A review of the nurses' notes, " Psychoactive Medication Monthly Flow Sheet" , social workers progress notes and physicians' progress notes for January and February 2009, revealed that there was no evidence that the resident resisted care, displayed anger and/or displayed inappropriate/disruptive behavior.

A face-to-face interview was conducted with Employee #28 at approximately 10:30 AM on April 21, 2009. He/she acknowledged that the coding for Section E1 and E4 was incorrect. He/she stated, "The coding for behaviors is incorrect. He/she used to have behavior outbursts but hasn't had any since the last hospitalization in January [2009]. I will correct the MDS." The record was reviewed on April 20, 2009.

2. Facility staff failed to accurately code Resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ___ B. WING ___ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 278 | Continued From page 25<br>#4 for cataracts.<br><br>According to the resident' s clinical record he/she was seen for a follow-up appointment by the ophthalmologist on July 31, 2008. A review of the " Report of Consultation," revealed that the resident' s diagnoses included cataracts and glaucoma.<br><br>A quarterly Minimum Data Set (MDS) was completed on October 3, 2008, an annual MDS was completed on January 3, 2009 and a quarterly was completed on April 2, 2009.<br><br>Facility staff failed to accurately code the resident for cataracts in Section I Disease Diagnoses of the annual MDS completed on January 3, 2009.<br><br>A face-to-face interview was conducted on April 23, 2009 at approximately 2:10 PM with Employees # 14 and 15, who acknowledged the aforementioned findings. The record was reviewed on April 23, 2009.<br><br>3. Facility staff failed to accurately code the MDS assessments for a hip fracture, use of a Foley and Pneumonia for Resident #5.<br><br>A. A review of the significant change MDS dated October 14, 2008 and quarterly MDS dated February 1, 2009 coded Resident #5 for having a hip fracture in Section I [Disease Diagnoses].<br><br>A. A review of the nursing notes, physician' s orders and progress notes from October, 2008 through February 2009 lacked evidence that Resident #5 had a hip fracture.<br><br>B. According to the Physical Examination | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 26<br>completed by the physician on October 13, 2008, the resident's diagnoses included Urinary Obstruction.<br><br>A review of the above cited MDS assessments revealed that there was no diagnosis for the use of the indwelling Foley catheter.<br><br>C. The nursing notes, physician' s orders and progress notes from October, 2008 through February 2009 lacked evidence that Resident #5 had Pneumonia.<br><br>A review of the quarterly MDS complete March 17, 2009 revealed that the resident was coded for Pneumonia in Section I2 e.<br><br>A face-to-face interview was conducted on April 21, 2009 10:30 AM with Employee #14. He/she acknowledged that the MDS was inaccurately coded for Diagnoses and Infections. The record was reviewed April 21, 2009.<br><br>4. Facility staff failed to correctly code Resident #7 for Pain on the quarterly Minimum Data Set (MDS).<br><br>A review of the quarterly MDS, completed February 27, 2009, in Section J2,"Pain Symptoms" was coded 2a for "Pain daily". Pain is coded 7 days prior to the ARD date, which was February 27, 2009.<br><br>A nursing note dated February 9, 2009 at 2:30 PM documented that the resident had fallen from a wheelchair and complained of pain in the right wrist. The resident was medication with `Tylenol 500 mg by mouth. | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ___ B. WING ___ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 27<br>A review of the February 2009 Medication Administration Record revealed that the resident received no pain medication after February 9, 2009.<br><br>A review of the nursing notes from February 10 through February 27, 2009 revealed that the resident had no further complaints of pain.<br><br>A face-to-face interview was conducted with Employee #8 on April 23, 2009 at 11:00 AM. He/she acknowledged, after reviewing chart, that the MDS was incorrectly coded for pain. The record was reviewed April 23, 2009.<br><br>5. Facility staff inaccurately coded Resident #8's MDS for Urinary Tract Infection (UTI).<br><br>A review of Resident #8's annual MDS assessment completed February 2, 2009 and a quarterly MDS assessment completed November 5, 2008 revealed that the resident was coded in section I(2) for UTI.<br><br>A further review of the resident' s clinical record including the physician' s progress notes, nursing notes, and physician order sheets all lacked documented evidence that the resident presented with UTI.<br><br>A face-to-face interview was conducted on April 23, 2009 at approximately 2:10 PM with Employees # 14 and 15. After reviewing the resident' s clinical record, they both acknowledged the aforementioned findings. The record was reviewed on April 23, 2009.<br><br>6. Facility staff failed to accurately code the quarterly MDS assessments for Resident #10 for | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 28<br>infections.<br><br>A review of the quarterly MDS assessments completed October 6, 2008 and January 1, 2009 coded Resident #10 for having a UTI [Urinary Track Infection] and MRSA [Methicillin-Resistant Staphylococcus Aureus] in Section I2 [Infections].<br><br>A review of the nursing notes and physician' s orders from October, 2008 through January 2009 lacked evidence that Resident #10 had a UTI and MRSA.<br><br>A face-to-face interview was conducted on April 27, 2009 4:15 PM with Employee #14. He/she acknowledged that the MDS was inaccurately coded for Infections. The record was reviewed April 27, 2009.<br><br>7. The facility staff failed to accurately code Section K3 (Weight Change) on Resident # 11's quarterly MDS.<br><br>A review of Section K of the resident' s quarterly MDS with an Assessment Reference Date (ARD) of October 27, 2008 revealed a weight of 188 lb and was coded in Section K3 for no Weight Change. However, a review of the admission MDS with an ARD of August 7, 2008 revealed a weight of 216 lb indicating a weight loss of 28 lb or 12% in three (3) months.<br><br>A face-to-face interview was conducted with Employee #27 at approximately 2:30 PM on April 23, 2009. He/she acknowledged that the resident was not coded for weight loss. The record was reviewed on April 22, 2009.<br><br>8. Facility staff failed to accurately code Resident | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING<br>B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 278 | Continued From page 29<br>#16 for restorative nursing, and inaccurately coded the resident for resisting care and socially inappropriate /disruptive behavioral symptoms.<br><br>A. A review of Resident #16's clinical record revealed "Physician's Order" sheets dated and signed by the physician on November 21, 2008, January 23, and April 3, 2009 that directed "Restorative nursing care per protocol" and first initiated on February 9, 2007.<br><br>A further review of the resident' s clinical record revealed that an annual MDS assessment completed on September 27, 2008, and quarterly MDS assessments completed on December 24, and March 22, 2008 failed to code the resident for restorative nursing care in Section P3 (Nursing Rehabilitation / Restorative Care).<br><br>A face-to-face interview with Employees #14 and 15 was conducted on April 23, 2009 at 2:10 PM. After reviewing the resident' s clinical record, they both acknowledged the aforementioned findings. The record was reviewed April 23, 2009.<br><br>B. According to Resident #16's quarterly MDS assessment completed March 22, 2009, the resident was coded in Section E4 (d-e) for resisting care and socially inappropriate /disruptive behavioral symptoms.<br><br>A review of the resident' s clinical record lacked documented evidence that the resident resisted care and presented with socially inappropriate /disruptive behavioral symptoms.<br><br>A face-to-face interview was conducted on April 23, 2009 at approximately 2:10 PM with | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 30<br>Employees #14 and 15. They both acknowledged that the MDS was inaccurately coded for abusive behavior. The record was reviewed on April 23, 2009.<br><br>9. Facility staff failed to accurately code the MDS for a UTI, pain and pressure sores for Resident #17.<br><br>A review of Resident #17' s record revealed that a quarterly MDS was completed on March 16, 2009. The ARD date was March 13, 2009.<br><br>A. Review of the quarterly MDS completed March 10, 2009, revealed that the resident was coded for a urinary tract infection within the last 30 days in Section I2 (Infections).<br><br>There was no evidence in the resident' s record that a urine culture showed growth of an organism to indicate that the resident had a urinary tract infection. There was no documentation that the resident displayed symptoms of a urinary tract infection.<br><br>According to the " MDS 2.0 User' s Manual" , page 3.136, " The diagnosis of a UTI, along with lab results when available, must be documented in the resident' s clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the MDS record." There was no evidence in the record that a correction to remove the diagnosis was completed.<br><br>B. The resident was coded in Section J2 (Pain Symptoms) as having moderate pain daily for seven (7) days prior to the ARD date. The nurses' notes from March 6 through March 13, | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 31<br>2009 and the March 2009 Medication Administration Record revealed that the resident did not complain of pain and was not medicated for pain for seven (7) days prior to the ARD date.<br><br>C. A resident was coded in Section M (Skin Condition) of the quarterly MDS completed March 10, 2009, for two (2) Stage IV wounds within seven (7) days of the ARD date. A review of the resident' s record revealed that the resident had two (2) pressure sores: one (1) sacral wound and one (1) left ankle wound at the time of the assessment.<br><br>According to the record, measurements of the sacral wound on March 10, 2009 were 3 cm x 2 cm x 0.1 cm and the left ankle wound 2cm x 1.5 cm x 0.1 cm. Both wounds were coded as Stage IV.<br><br>According to the " MDS User 2.0 Manual" page 3-159, described a Stage 4 ulcer as, " A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone."<br><br>There was no evidence that the sacral and left ankle wound appeared as Stage IV ulcers as described above.<br><br>A face-to-face interview was conducted with Employee #14 on April 23, 2009 at 8:30 AM who acknowledged that Sections I, J and M were not accurately coded as cited above. The record was reviewed April 23, 2009.<br><br>10. Facility staff failed to accurately code Resident # 18' s quarterly MDS for Section M, (Pressure Ulcer.) | F 278 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 278 | Continued From page 32 | F 278 | | |

A review of the quarterly MDS completed January 23, 2009 with an Assessment Reference Date of January 14, 2009 revealed that the resident was coded for one (1) Stage II pressure ulcer in Section M1B (# of Stage 2 ulcers). A review of the Weekly Wound Healing Record revealed that on December 31, 2008, January 7, 2009 and January 14, 2009 the ulcer was documented as unstageable.

A face-to-face interview was conducted with Employee # 28 at approximately 10:00 AM. The employee acknowledged the aforementioned findings. The record was reviewed on April 23, 2009.

11. Facility staff inaccurately coded Resident #20's MDS for resisting care.

A review of Resident #20's quarterly MDS assessment completed April 2, 2009 revealed that the resident was coded for resisting care in section E4(e) (Behavioral symptoms). A review of the resident' s clinical record lacked documented evidence that the resident resisted care.

A face-to-face interview was conducted on April 23, 2009 at approximately 2:10 PM with Employees #14 and 15. After reviewing the resident' s clinical record, they both acknowledged that the MDS was inaccurately coded for resisting care. The record was reviewed on April 23, 2009.

12. The RN assessment coordinator failed to sign the admission MDS face sheet for Resident #28.

A review of the admission MDS completed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 278 | Continued From page 33<br>September 30, 2008 revealed that Section AD " Face Sheet Signatures" was blank. The RN coordinator failed to sign and date Section ADa, " Signatures of Persons Completing Face Sheet."<br><br>A face-to-face interview was conducted on April 22, 2009 at 3:30 PM with Employee #14 who acknowledged that Section AD was not signed. The record was reviewed April 22, 2009.<br><br>13. Facility staff failed to accurately code the MDS for Dyslipidemia and Adult Failure to Thrive for Resident A1.<br><br>According to the resident's History and Physical completed and signed on April 8, 2008, included diagnoses of Dyslipidemia and Adult Failure to Thrive.<br><br>A review of the resident's Medication Administration Record (MAR) for February and March 2009 revealed that the resident was consistently administered Pravastatin 20mg daily.<br><br>A review of the resident's annual MDS completed on March 4, 2009 failed to code the resident for Dyslipidemia and Adult Failure to Thrive in Section I (Disease Diagnoses).<br><br>A face-to-face interview was conducted with Employees #14 and 15 on April 23, 2009 at approximately 2:30 PM. After a review of the resident's record the Employees #14 and 15 acknowledged that the resident was not accurately coded for Dyslipidemia and Adult Failure to Thrive in Section I (Disease Diagnoses). | F 278 | | |
| F 279<br>SS=E | 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS | F 279 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 279 | Continued From page 34<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for five (5) of 30 sampled residents and one (1) of 12 supplemental residents, facility staff failed to initiate care plans for: one (1) resident with a swollen scrotum; one (1) resident for vision; one (1) resident for anticoagulant therapy; one (1) resident for side rails; one (1) resident for the potential interaction of the use of nine (9) or more medications; and one (1) resident for edematous bilateral lower extremities. Residents # 8, 12, 13, 28, 30 and A4.<br><br>The findings include: | F 279 | 1. Resident #8 was reassessed, no scrotal swelling was observed. MD was called and scrotal support was placed. Unable to retrospectively correct care plan. Resident #12 indicated in the opening statement is #4, based upon narrative written. Resident #4 frequently takes glasses off. When encouraged to wear glasses, residents states "I don't need to wear glasses all the time". A care plan was developed to address the needs of eye glasses and the refusal of wearing them, Resident #13's care plan was updated to include anticoagulant therapy. Resident #28and #30 are closed records. Resident #A 4 was reassessed and a care plan was developed to address bilateral lower extremities. The resident was provided a foot stool.<br><br>2. A review of the care plans is completed quarterly with the MDS and when there is a change in condition.<br><br>3.The interdisciplinary team will be re-educated on the resident assessment process.<br><br>4. A review of the care plan is a part of the comprehensive medical record audit. The tool is completed monthly and findings are presented at the quarterly QA meeting. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 279 | Continued From page 35<br>1. Facility staff failed to initiate care plan for swollen scrotum for Resident #8.<br><br>A review of the resident's clinical record revealed that the resident was seen by the attending physician on February 3, 24, March 15, and 22, 2009 as evidenced by the attending physician' s progress notes that indicated under "Impression" scrotal swelling.<br><br>According to the resident's clinical record, an "Interim Order Form" dated and signed by the physician on February 3, 2009 revealed an order that directed "Provide scrotal support to patient".<br><br>A further review of the resident's care plans last updated on February 3, 2009 lacked evidence that a care plan was developed with goals and approaches to address the resident's swollen scrotum.<br><br>A face-to-face interview was conducted with Employee #8 on April 21, 2009 at approximately 2:00 PM. He/she acknowledged that the resident's clinical record lacked evidence that a care plan was initiated with goals and approaches to care for the resident' s swollen scrotum. The record was reviewed April 22, 2009.<br><br>2. Facility staff failed to initiate a care plan for impaired vision for Resident #4.<br><br>A review of Resident # 4's record revealed a physician's "Interim Order Form" with telephone orders dated July 31, 2008 and signed by the physician on September 5, 2008 directed the followings:<br><br>At 8:00 AM "Ophthalmology consult due 7/31/08... | F 279 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 279 | Continued From page 36 | F 279 | | |

[Hospital]..."
At 2:30 PM "Schedule eye [eye glasses] fitting appointment, F/U eye check in 6 month due January '09"

A further review of the resident's clinical record revealed the following nurses' note "7/31/08 at 3:00 PM Resident alert and verbally responsive ...Left the unit with escort at 10:30 AM for eye appointment at [ ...hospital] with [Dr ...] Returned at 2:20 PM with recommendation that the Resident request for eye glasses. Consult given to unit clerk to make the eye
[eye glasses] fitting appointment. F/U [Follow up] eye check in 6 month. Due January 2009. MD made aware ..."

"April 1, 2009 4:00 PM Resident left the unit at 9:00 AM for eye [eye glasses] fitting appt. [Appointment] at [ ...Hospital]. Return at 11:00 AM. Eye [eye glasses] fitting done. Waiting for eye glasses ..."

Review of the resident's clinical record lacked evidence that a care plan was developed with goals and approaches to address the resident's impaired vision and/or the use of eye glasses.

A face-to-face interview was conducted on April 23, 2009 at approximately 11:00 AM with Employee #11. He/she acknowledged a care plan was not initiated for impaired vision and the use of eye glasses. The record was reviewed April 23, 2009.

3. Facility staff failed to initiate a care plan for anticoagulant therapy for Resident #13.

According to a physician's order dated November

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 279 | Continued From page 37<br>10, 2008, the resident was prescribed "Plavix 75 mg daily and Aspirin 325 mg daily." The orders were renewed December 23, 2008, and January 2 and March 9, 2009.<br><br>The care plan was reviewed by the interdisciplinary team on February 3 and April 23, 2009. There was no evidence that a care plan with appropriate goals and approaches was developed for anticoagulant therapy.<br><br>A face-to-face interview was conducted with Employee #8 on April 23, 2009 at 1:40 PM who acknowledged the lack of a care plan for anticoagulant therapy. The record was reviewed April 23, 2009.<br><br>4. Facility staff failed to initiate a care plan for the use of side rails for Resident #28. This was a closed record.<br><br>According to the admission MDS assessment completed September 30, 2008, the resident was admitted to the facility on September 23, 2009 and was coded for the use of full side rails daily in Section P4 (Devices and Restraints). The facility had identified that the use of side rails for Resident #28 was a restraint.<br><br>The interim care plan was initiated by the interdisciplinary team on September 24, 2009 and failed to include a care plan with appropriate goals and approaches for the use of side rails. The record was reviewed April 22, 2009.<br><br>5. Facility staff failed to initiate care plans for the potential adverse interaction for the use of nine (9) or more medications for Resident #30. This was a closed record. | F 279 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 279 | Continued From page 38 | F 279 | | |

A review of Resident #30 revealed that the resident was admitted to the facility on August 1, 2008. According to the admission orders signed August 18, 2008 and most recently renewed on April 11, 2009, the resident was prescribed the following medications: Imuran, Colace, Folic Acid, Glipizide, Atarax, Ferrous Sulfate, Vitamin C with Senna, Calcium with Vitamin D, Mevacor, Metformin, Prednisone, Multivitamin, Ambien, and Lopressor.

The care plan was reviewed by the interdisciplinary team on August 1 and November 8, 2008 and February 13, 2009. There was no evidence that a care plan with appropriate goals and approaches was developed for the potential adverse interaction of nine (9) or more medications. The record was reviewed April 23, 2009.

6. Facility staff failed to initiate a care plan for edematous bilateral lower extremities for Resident A4.

Resident A4 was observed seated in a wheel chair in his/her room on April 24, 2009 at approximately 11:45 AM. The resident' s bilateral lower extremities were observed edematous. The resident acknowledged that his/her feet were edematous and that he/she had requested a step stool since February 2009 to help minimize the edema. He/she said that he/she was told that the physical therapy department would be supplying him/her with the step stool.

A review of the resident's History and Physical, Physician's Progress Notes, and Nurses Notes revealed that the resident had bilateral lower

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 279 | Continued From page 39<br>extremity edema.<br><br>A review of the resident's care plans last updated on February 3, 2009 lacked evidence that a care plan was developed with goals and approaches to address the resident's bilateral edematous lower extremities.<br><br>A face-to-face interview was conducted on April 27, 2009 at 11:00 AM with Employee #11. He/she acknowledged that a care plan for edematous bilateral lower extremities was not developed. The record was reviewed on April 27, 2009. | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced | F 280 | 1. The records for Residents #1, 10, 13, 18, 23 and 29 were reviewed. The residents were also assessed. The plan of care of residents #1, 10,18,23,29 were updated. The psychiatrist was contacted for resident #13.<br><br>2. The care plan for the residents in the facility are reviewed quarterly and with a change in condition, with the MDS and are then updated. In addition, changes in the resident's condition indicated care are reviewed and updated when indicated.<br><br>3. The Nurse Managers will be re-educated on the resident instrument program. The interdisciplinary team will be re-educated on the care planning process.<br><br>4. Review of care plan and its accuracy is a part of the nursing comprehensive medical record audit completed monthly and is presented in the quarterly Quality Assurance Committee meetings. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 280 | Continued From page 40<br>by:<br>Based on record review and staff interview for six (6) of 30 sampled residents, it was determined that facility staff failed to revise and review care plans for: one (1) resident on Remeron, three (3) residents with pressure sores, two (2) residents who were verbally aggressive and one (1) resident after a quarterly review. Residents #1, 10, 13, 18, 23 and 29.<br><br>The findings include:<br><br>1. Facility staff failed to update the use of Remeron and the current status of pressure ulcers for Resident #1.<br><br>A. The Report of Consultation dated December 16, 2008 revealed, " ...Recommendations: continue current course of treatment ...Remeron 45 mg daily for Depression" .<br><br>According to the significant change Minimum Data Set completed November 21, 2008 revealed that Depression was coded in Section I [Disease Diagnoses].<br><br>The March 2009 physician' s orders dated and signed by the physician April 4, 2009 " ...Mirtazepine tab 45mg for: Remeron take 1 tablet via peg-tube daily for appetite ... Psych consult as needed ..."<br><br>The care plans last updated January 16, 2009 lacked evidence that a care plan for the use of Remeron was initiated with goals and approaches for Depression and/or the use of Remeron for appetite.<br><br>A face-to-face interview was conducted on April | F 280 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 280 | Continued From page 41<br>22, 2009 at 3:50 PM with Employee #16. He/she acknowledged that there was no care plan initiated for the use of Remeron. The record was reviewed April 22, 2009.<br><br>B. Facility staff failed to update " Problem #9 ...Acute Pain R/t [related to] pressure ulcer Pain site left heel eschar ..." for Resident #1.<br><br>A review of the care plans last updated January 16, 2009 revealed, " Problem #9 ...Acute Pain R/t [related to] pressure ulcer Pain site left heel eschar ..."<br><br>According to the Minimum Data Set dated November 21, 2008 coded Resident #1 for a missing limb in Section I [Disease Diagnoses].<br><br>A review of the " Attending Physician Progress Notes" dated November 17, 2008 revealed, " ...Physical-General: ... Left lower limb stump..."<br><br>The care plan lacked evidence that it was updated to reflect that the resident' s left leg was amputated.<br><br>A face-to-face interview was conducted on April 22, 2009 at 3:50 PM with Employee #16. He/she acknowledged that the care plan was updated to reflect Resident #1' s left leg amputation. The record was reviewed April 22, 2009.<br><br>2. Facility staff failed to update " Problem #9 ...Acute Pain R/t [related to] pressure ulcer for Resident #10.<br><br>A review of the care plans last updated March 24, 2009 revealed, " ...Pressure ulcer ..." | F 280 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 280 | Continued From page 42 | F 280 | | |

A review of the " Weekly Wound Healing Record" dated March 24 and 30, April 4 and 7, 2009 revealed, " Site/Location: L Buttock Ulcer, Stage-4 ..."

The care plan lacked evidence that it was updated to reflect that Resident #10' s Stage 4 ulcer was on the left buttock.

A face-to-face interview was conducted on April 27, 2009 at 4:15 PM with Employee #12. He/she acknowledged that the care plan was not updated to reflect Resident #10' s left buttock wound. The record was reviewed April 27, 2009.

3. Facility staff failed to follow interventions initiated after a resident-to-resident altercation for Resident #13 in a timely manner.

A review of Resident #13' s record revealed a nurse' s note dated October 7, 2008 at 7:30 PM, " Resident was sitting in hallway in front of the nurse' s station when a male wheel chair resident ...backed into resident' s chair. [Resident #13] turned around and started to hit the male resident ..."

According to care plan problem, #20 " Resident has physically abusive behavioral symptoms (others were hit, shoved, scratched)." Hand written under " Problems" was, " Resident scratched a male resident ... (who) bumped into [his/her] chair - 10/7/08." Under approaches was the following hand written statement, " 10/7/08 - Psyc (psychiatric) consult for behavioral therapy."

There was no evidence in the record that the psychiatrist had seen the resident as a result of the October 7, 2008 incident. The behavioral

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 280 | Continued From page 43 | F 280 | | |

therapist saw the resident on February 2, 2009. According to the consult report, " [He/she] denied any additional incidents of aggression." The behavioral therapist did not reference the incident of October 7, 2008.

A face-to-face interview was conducted with Employee #8 on April 23, 2009 at 1:40 PM, who acknowledged that there was a four (4) month delay in obtain the behavioral therapist consult. The record was reviewed April 23, 2009.

4. Facility staff failed to update Resident #18' s care plan for pressure ulcers.

According to the Weekly Wound Healing Records dated December 31, 2008, January 7, 2009, and January 14, 2009 Resident #18 had an unstageable pressure ulcer on the right heel.

A review of the Physician' s Progress Notes dated March 18, 2009 revealed the following documentation from the physician, " Patient seen by Wound Team. Has right heel eschar ... Plan: pressure relief."

A review of the Interdisciplinary Care Plan revealed that a Pressure Ulcer Care Plan was initiated on October 20, 2008. However further review of the same care plan revealed the following documentation dated January 21, 2009, " Rt (right) heel healed. Rt (right) ankle healed. Lt (left) heel eschar. Wound Tx (Treatment) D/c' d (discontinued). Documentation on the care plan was resumed on April 23, 2009.

A face-to-face interview was conducted with Employee #28 at approximately 10:00 AM on April 23, 2009. He/she acknowledged the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING<br>B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 280 | Continued From page 44 | F 280 | | |

aforementioned findings. The record was reviewed on April 23, 2009.
5. Facility staff failed to revise and review Resident #23' s verbally abusive care plan.

A review of Resident #23' s record revealed a care plan initiated on January 8, 2009, " Resident has verbally abusive behavioral symptoms (others were threatened, screamed at, curse at.)." The care plan was initiated as a result of a verbal altercation between the gift shop manager and the resident.

A hand written entry dated March 5, 2009, documented, "Staff member reported resident with verbal abusive behavior to [him/her] using curse words."

There was no evidence that the care plan was revised to include additional goals and approaches in response to the March 5, 2009 incident.

A face-to-face interview was conducted with Employee #8 on April 24, 2009 at 2:45 PM who acknowledged that the care plan had not been updated after the March 5, 2009 incident. The record was reviewed April 24, 2009.

6. Facility staff failed to review and revise Resident #29' s care plan after completing a quarterly Minimum Data Set (MDS) assessment completed April 2, 2009. This was a closed record.

A review of Resident #29' s record revealed a quarterly MDS completed April 2, 2009. A review of the resident' s care plan revealed that the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 280 | Continued From page 45<br>interdisciplinary team last reviewed the care plan on January 21, 2009. There was no evidence in the record that the care plan was reviewed after the completion of the quarterly MDS on March 5, 2009. | F 280 | | |
| F 281<br>SS=D | 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations during the medication pass for one (1) of 12 supplemental residents, it was determined that facility staff failed to use the appropriate size blood pressure cuff to obtain Resident JH2's blood pressure.<br><br>The findings include:<br><br>On April 27, 2009 at approximately 9:00 AM, during medication pass for Resident JH2, Employee #42 attempted to take the resident ' s blood pressure with a cuff which was too small for the resident's arm. Employee #42 was unable to position and secure the blood pressure cuff around the resident's upper arm.<br><br>When asked about the blood pressure cuff being too small, the employee stated, " I usually use the automatic cuff to take the resident's pressure. "<br><br>Employee #42 retrieved a wrist cuff blood pressure machine and took the resident's blood pressure. The reading was 119/59. The cuff did not fit correctly. Employee #42 was asked by the surveyor to take the blood pressure with a cuff for | F 281 | 1. Resident JH2's blood pressure was rechecked with the appropriate size cuff. An obese cuff has been placed on the unit.<br><br>2. A review of all obese residents on antihypertensive drug therapy for BP cuff fitting was done.<br><br>3. The licensed staff were re-educated regarding using appropriate equipment for blood pressure, and not to use their own personal equipment.<br><br>4. Monitoring of Med Pass conducted monthly by Nursing Staff, including use of BP equipment prior to administration of medication. This information will be presented to the quarterly QA committee meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 281 | Continued From page 46<br>obese patients. When the blood pressure was taken with the larger cuff the reading was 130/90.<br><br>A face-to-face interview was conducted at the time of the incident. Employee #42 stated that the he/she usually takes the resident's blood pressure with the wrist cuff, but he/she will now use the larger cuff for obese residents. | F 281 | | |
| F 309<br>SS=E | 483.25 QUALITY OF CARE<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview for seven (7) of 30 sampled residents and two (2) of 12 supplemental residents, it was determined that facility staff failed to: follow up on an order for gastrointestinal and barium enema consult/appointment and vancomicyn levels for one (1) resident, follow the physician's order for pacemaker checks for one (1) resident, follow physician's orders to monitor Dilantin levels for one (1) resident, follow the physician's order to provide scrotal support for one (1) resident, follow the recommendation for one (1) resident to go to day program, obtain a physician's order for use of hand splint for one (1) resident, follow a physician's order to discontinue finger stick and Foley for one (1) resident, follow up on an order for positive breast examination for one (1) resident and properly administer inhalation | F 309 | 1. Resident #1 showed no signs and symptoms of Gastrointestinal bleeding and/ distress. Gastrointestinal consult and barium enema study was discontinued by the physician. Resident is no longer on antibiotic therapy. Unable to retrospectively correct Resident #3's pacemaker check was done and found to be accurate. Resident #7's dilantin level was checked and was normal. Resident #8 was re-assessed and no scrotal edema was noted. Resident #13 was reassessed by Social Services in consultation with counselor. It was determined that behavioral counseling would continue but a day program was no longer a viable recommendation. Resident #16 was re-evaluated and an order for a splint has been obtained. Resident #28 was a closed record unable to retrospectively Correct. Resident #F1 has received follow-up treatment. **Resident #JH1 is not a resident at the center.**<br><br>2. A review of all residents appointments and physicians orders for the last quarter was done. A 24 hour chart audit of physician orders was completed.<br><br>3. The licensed nursing staff were in-serviced on physicians orders including there implementation, documentation and follow-up of appointments.<br><br>4. A comprehensive medical records audit is apart of the QA program. This information is presented to the QA committee. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 309 | Continued From page 47<br>medication. Residents #1, 3, 7, 8, 13, 16, 28, F1 and JH1.<br><br>The findings include:<br><br>1. Facility staff failed to follow up on a GI [Gastrointestinal] consult, barium enema study and follow up on laboratory studies for use vancomycin for Resident #1 as ordered by the physician.<br><br>A. Facility staff failed to follow up on a GI [Gastrointestinal] consult and barium enema study.<br><br>A review of the telephone orders revealed the following:<br><br>" February 25, 2009 at 11:30 AM revealed, " ...GI Consult with [doctor ' s name] for blood in stool ... "<br><br>" March 14, 2009 at 5:30 PM revealed, " Barium enema for incomplete colonoscopy ... "<br><br>A review of the clinical record lacked evidence that the GI consult and the Barium enema incomplete colonoscopy was scheduled and/or completed in a timely manner.<br><br>Additionally, there was no date on the " Request for Consult " form to note when the request form was initiated and/or sent to the scheduler to set up the appointment(s) for Resident #1.<br><br>A face-to-face interview was conducted on April 23, 2009 at 2:30 PM with Employee #17. He/She stated, " He/she has not been out [for appointments]. We have not scheduled any | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 309 | Continued From page 48 | F 309 | | |

appointment for the GI consult and the Barium study is scheduled for May 4, 2009 at [hospital]. The appointment was scheduled last Monday [April 20, 2009]. The record was reviewed April 23, 2009.

B. Facility staff failed to follow up on laboratory studies for Resident #1 receiving vancomycin.

The Physician ' s order dated October 27, 2008 at 2P [2:00 PM] " ...Do vanco peak and trough on 10/28/08 in AM. "

A review of the nurse ' s notes revealed the following:

" October 27, 2008 at 11P [11:00 PM] ABT [antibiotic] vanco [vancomycin] on hold October 27, 2008 and October 28, 2008. Peak and trough to be done [in the] AM October 28, 2008 ... "

" October 28, 2008 6AM [6:00 AM] vancomycin remains on hold. At this time no adverse reaction to ABT noted ... Scheduled to go to attending physician this AM for re-evaluation ... "

" October 28, 2008 3P [3:00 PM] ...depart unit 10:30 AM via [ambulance name] with two (2) attendants to [hospital] for further evaluation on left foot ulcer ... "
" October 28, 2008 3:15 PM Resident had been admitted at [hospital] ... "

The record lacked evidence that Resident #1's peak and trough were obtained prior to leaving the facility for a scheduled appointment October 28, 2008.

A face-to-face interview was conducted on April

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 309 | Continued From page 49<br>23, 2009 at 2:30 PM with Employee #17. He/she acknowledged that the peak and trough was drawn on October 28, 2009 as ordered. The record was reviewed on April 23, 2009.<br><br>2. Facility staff failed to schedule a pacemaker evaluation/assessment every three (3) months as ordered by the physician for Resident #3.<br>A review of Resident # 3's record revealed a physician's order signed and dated December 15, 2008 that directed, "Pacemaker check every 3 months: March, June, September".<br>A review of resident ' s March 2009 MAR revealed a pacemaker check schedule for March 15, 2009. There was no report of the pacemaker check in the record.<br>There was no evidence in the record that the resident had a pacemaker check in March as per the physician's order.<br>A face-to-face interview was conducted with Employees #11 and #13 on April 21, 2009 at approximately 11:00 AM. They acknowledged that the resident did not have a pacemaker check in March 2009 because there was no information on the type of the pacemaker.<br>An interview with a family member by Employee #11 on April 22, 2009, provided the information the facility needed regarding the type of pacemaker the resident had implanted.<br>A follow up face-to-face interview was conducted with Employee #11 and #13 on April 22, 2009 at 2:00PM. They stated that the family member provided the information required to schedule a pacemaker check.<br>The pacemaker was checked on April 22, 2009. This record was reviewed April 22, 2009<br><br>3. Facility staff failed to ensure that Dilantin levels were drawn for Resident #7 as ordered by the | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 309 | Continued From page 50 | F 309 | | |

physician.

A review of the Physician Order Sheet (POS) dated and signed by the physician on December 21, 2008 directed the following: "Labs- Dilantin, levels every month, Diagnosis- Seizure disorder".

A review of the " (Company) Lab Test Log " revealed that Resident #7's Dilantin level was drawn January 12, 2009, at 5:30AM.

A review of the laboratory section of the record lacked evidence that blood was drawn for the Dilantin level for January 2009.

A review of the clinical records and " Nursing Monthly Summary Form " revealed no seizure activity or any untoward effect reported for January 2009.

A face-to-face interview was conducted with Employee #8 on April 27, 2009 at 10:45 AM. He/she acknowledged that the Dilantin level was drawn for January 2009 and the results were not on the chart.

A follow up face-to-face interview was conducted with Employee #8 on April 27, 2009 at 2:15 PM. He/she presented " (Company) Lab Test Log " to show as proof that Dilantin labs were drawn on January 12, 2009.

Another follow up face-to-face interview Employee #8 called for Dilantin level results from the company. The company had no record of the Dilantin level being drawn on January 2009. The record was reviewed on April 27, 2009.

4. Facility staff failed to provide Resident #8 with

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING<br>B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 309 | Continued From page 51 | F 309 | | |

a scrotal support as ordered by the physician.

A review of the resident's clinical record revealed that the physician wrote progress notes on February 3, 24, March 15, and 22, 2009 and indicated under "Impression" scrotal swelling.

An "Interim Order Form" reviewed in the resident's clinical record dated and signed February 3, 2009 directed "Provide scrotal support to patient."

There was no evidence in the resident's clinical record that the facility staff provided the resident with the scrotal support as ordered by the physician.

A face-to-face interview was conducted with Employee #8 on April 21, 2009 at approximately 2:00 PM. After a review of the resident's record, he/she acknowledged that the resident was not provided a scrotal support as ordered by the attending physician.

A face-to-face interview was conducted with Employee #32 on April 22, 2009 at approximately 12:10 PM. After a review of the resident's clinical record, he /she acknowledged that the resident was not provided a scrotal support as per the attending physician's order by the rehabilitation department because the department has nothing to do with scrotal support. The record was reviewed April 22, 2009.

5. Facility staff failed to follow the recommendation for Resident #13 to attend a day program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 309 | Continued From page 52<br>A review of Resident #13's record revealed a consulting behavioral therapist' s report that was conducted on February 19, 2009. "Recommendations" written included, "Continue individual counseling to help with sadness and frustration as well as maintain mental status. 2. Day program or activity outside the facility."<br><br>Social worker progress notes for February 19 and April 23, 2009 were reviewed. There was no evidence that the social worker had followed up on the above cited recommendation.<br><br>There was no evidence that the nursing staff followed-up on the recommendation for the resident to attend a day program.<br><br>Employees #4, 25 and 7 acknowledged that there was no follow-up to the recommendation for Resident #13 to attend a day program. The record was reviewed April 23, 2009.<br><br>6. Facility staff failed to obtain a physician's order for use of hand splint for Resident #16.<br><br>Resident # 16 was observed during a wound care dressing on April 23, 2009 at approximately 12:25 PM wearing a hand splint.<br><br>A review of the resident's record lacked evidence that the facility staff obtained a physician's order to administer a hand splint to the resident.<br><br>A face-to-face interview was conducted with Employee # 28 on April 27, 2009 at approximately 3:00 PM. After a review of the resident's record and an observation of the resident, he/she acknowledged that the resident's clinical record lacked evidence that the facility staff obtained a | F 309 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 309 | Continued From page 53<br>physician's order to administer a hand splint to the resident. The record was reviewed April 27, 2009.<br><br>7. Facility staff failed to: discontinue a Foley catheter and perform finger sticks as per physician ' s orders for Resident #28, a closed record review.<br><br>A. Facility staff failed to discontinue a Foley catheter as per physician ' s orders.<br><br>Admission orders dated September 23, 2008 and signed by the physician on September 28, 2009 included the order, " D/C (discontinue) Foley 9/23/08. "<br><br>According to the following nurses ' notes:<br>September 24, 2008 at 6:45 AM, " ...Foley catheter in place with minimal drainage noted ... "<br>September 24, 2008 at 10:30 PM: " Foley intact and draining freely ... "<br>September 25, 2008 at 6:00 AM: " Foley cath in place draining freely ... "<br><br>On September 25, 2008 at 7:00 PM, a telephone order signed by the physician on October 27, 2008 directed, " D/C Foley cath. "<br>According to a nurse ' s note dated September 25, 2008 at 10:00 PM, " Foley cath D/C (discontinued) ... "<br><br>A face-to-face interview was conducted with Employee #2 on April 23, 2009 at 5:30 PM, who acknowledged the above findings.<br><br>B. Facility staff failed to perform finger sticks for measuring blood glucose levels as per the physician ' s order. | F 309 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING<br>B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 309 | Continued From page 54 | F 309 | | |

Continued From page 54

According to physician ' s orders dated September 23, 2008, " Finger sticks twice daily for 14 days to monitor Dexamethasone use. " Fingersticks measured the resident ' s blood glucose level.

According to the September 2008 Medication Administration Record, finger sticks were identified by the facility to be done September 26 through October 9, 2008 at 6:00 AM and 5:00 PM daily. There was no blood glucose level recorded for September 27, 28 and 29, 2008 at 5:00 PM. A review of the nurse ' s notes for September 27, 28 and 29, 2008 revealed that no blood glucose levels were recorded.

A face-to-face interview was conducted with Employee #2 on April 23, 2009 at 5:30 PM, who acknowledged the above findings. The record was reviewed April 23, 2009.

8. Facility staff failed to follow up a positive finding to the left breast for Resident F1.

A review of a radiology report dated December 3, 2007 revealed, " ...Diagnosis: Routine GYN Exam, Examination: Mammogram Bilat diag [bilateral diagnostic] ...Full Result: Clinical History: Left breast mass ... Impression: Clinical History: Left breast mass ...Examination of the left breast shows an area of density in the lower-inner quadrant. This area is suspicious and biopsy is recommended. A sonogram was performed on this patient and a sonographic report is to follow. The mass mammographically and sonographically is suspicious and biopsy is recommended. "

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 309 | Continued From page 55 | F 309 | | |

A review of the Attending [physician ' s note] dated December 12, 2007 did not mention the positive findings to the left breast.

A review of Resident F1 ' s Physical Examination form dated February 20, 2008 revealed, " ...Chest/Breast: left breast mass ... "

A review of the physician ' s order written signed and dated July 25, 2008 revealed, " Please make an appointment with interventional radiology ... at [name of hospital] for breast biopsy (left breast) ASAP. "

A review of the nursing notes revealed the following:

September 10, 2008 at 4 PM revealed, " Resident left the unit to Cancer Institute for breast biopsy at [hospital] (left breast). Procedure not done rescheduled for September 17, 2008 at 10:30 AM ... "

A review of the clinical record lacked evidence that the appointment was scheduled for the follow up to the positive finding to the left breast.

A face-to-face interview was conducted on April 22, 2009 at 1:30 PM with Employee #26. He/she acknowledged that there was no follow up from February 20, 2008 to September 17, 2008. The record was reviewed on April 23, 2009.

9. Facility staff failed to properly administer inhalation medication to Resident JH1.

A physician's order dated and signed February 13, 2009, directed, " AdvAIR Diskus 250/50,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 309 | Continued From page 56<br>inhale [1] puff by mouth twice daily for [COPD], Flovent HFA 44mcg, inhale [2] puffs by mouth twice daily for [COPD], and SPIriva Cap 18mcg handihaler, take [1] capsule via handihaler by mouth daily for [COPD]."<br><br>On April 20, 2009, at approximately 10:00 AM during the medication pass, Resident JH1 was administered Advair 250/50 one puff, Spiriva 18mcg one puff and Flovent 44 mcg two puffs. Employee #42 administered the inhalers to the resident without spacing them.<br><br>A review of the facility's policy and procedure , 5.3.2 "Oral and Nasal Inhalation Administration", stipulates "If more than one inhalation is ordered, wait one minute, then repeat steps ... for each inhalation.<br><br>A face-to-face interview was conducted on April 20, 2009 , at approximately 10:30 AM. with Employee #28. He/she stated, "[Employee #42] may have administered it incorrectly." | F 309 | | |
| F 311 SS=D | 483.25(a)(2) ACTIVITIES OF DAILY LIVING<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review, and staff and resident interviews, for one (1) of 12 supplemental residents, it was determined that facility staff failed to provide appropriate and requested services to maintain and or improve Activities of Daily Living (ADL) abilities. Resident A1. | F 311 | 1. Resident #A1 has been assessed and the record reviewed. A meeting was held with the Medical Director regarding this resident. He is independent in ADL and has no edema.<br><br>2. A review of wheelchairs, footstool, and low beds in the facility has been conducted.<br><br>3. Facility will continue to support resident independence, and monitor for any changes that might indicate additional needs.<br><br>4. The monthly comprehensive medical record audit addresses physician/family notification. This tool is completed monthly, and results are presented quarterly to the QA Committee. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 311 | Continued From page 57 | F 311 | | |

The findings include:

Facility staff failed to provide appropriate and requested services to maintain and or improve the resident's ADL abilities including toileting and transfer. Resident A1.

Resident A1 was observed during an investigative tour of the facility seated in a wheel chair in his/her room on April 24, 2009 at approximately 11:45 AM. The resident's bilateral lower extremities were observed edematous.

The resident acknowledged that his/her feet were edematous and that the facility had failed to provide him/her with appropriate and functioning wheelchair to enable him/her to maintain and or improve his/her toileting and transfer abilities. The resident stated: "I have not had any functioning wheel chair. I had to constantly remove the footrest from the wheelchair each time I need to use the bathroom, tired of on and off, I took it off because I was always getting hurt each time I take it off to use the bathroom. Then sometime in February, I asked for something/a stepstool to elevate my feet while in my room. I was told that the physical therapy department will be supplying me with a step stool. I used to have a low bed on the previous floor, and requested that I have that bed here to help with easy transfer in and out of bed. I am yet to be given the low bed."

A review of the resident's clinical record: History and Physical, Physician's Progress Notes, and Nurses Notes revealed that the resident was admitted to the facility on September 19, 2008 and that the resident has bilateral lower extremity edema.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ___ B. WING ___ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 311 | Continued From page 58<br><br>Facility staff failed to provide appropriate and requested services (wheelchair, footstool and low bed) to help maintain and or improve the resident's ADL abilities including toileting and transfer. Resident A1.<br><br>A face-to-face interview was conducted on April 24, 2009 at approximately 2:45 PM with Employee #3. After reviewing Resident A1's clinical record, he/she acknowledged that the resident took the footrest off the wheelchair because of the hindrance to independent bathroom use and that an order has been placed for a new wheelchair for the resident's.<br><br>On April 27, 2009 at approximately 2:00 PM, a footstool was observed by the resident's bedside. The resident was out of the facility for a medical appointment and therefore was not available for a follow-up interview. The record was reviewed on April 27, 2009. | F 311 | | |
| F 313 SS=D | 483.25(b) VISION AND HEARING<br><br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review, staff and resident interview for three (3) of 30 samples | F 313 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 313 | Continued From page 59<br>residents, it was determined that facility staff failed to: follow up with an impaired vision assessment and ensure proper treatment for two (2) residents, and follow up with a physician order and ensure prompt receipt of eye glasses to maintain vision for one (1) resident. Residents # 4, 12 and 16.<br><br>The findings include:<br><br>1. Facility staff failed to ensure prompt receipt of an eye glasses to maintain vision as ordered by the physician for Resident # 4.<br><br>A review of Resident # 4's record revealed a physician's "Interim Order Form" dated July 31, 2008 and signed by the physician on September 5, 2008 that directed: "T.O...(1) Schedule eye [Eye glasses] fitting appt. (appointment)..."<br><br>A further review of the resident's clinical record revealed the following nurses' note of July 31, 2008 at 3:00 PM: "Resident alert and verbally responsive...Left the unit with escort at 10:30 AM for eye appointment at [ ...hospital] with [Dr ...] Returned at 2:20 PM with recommendation that the Resident request for eye glasses. Consult given to unit clerk to make the eye [Eye glasses] fitting appointment. F/U [Follow up] eye check in 6 month. MD made aware."<br><br>"April 1, 2009 4:00 PM Resident left the unit at 9:00 AM for eye fitting appt. [Appointment] at [ ...Hospital]. Return at 11:00 AM. Eye [Eye glasses] fitting done. Waiting for eye glasses ... "<br><br>There was no documentation in the resident's record to explain the eight (8) month delay in obtaining the resident's glasses. | F 313 | 1. Resident #4 was seen by ophthalmologist and received glasses. Resident #12 and 14 were coded on the MDS as having impaired vision, however, no documentation from physician and/or nursing that he had vision a modification to MDS had been completed.<br><br>2. Review of all resident charts with impaired vision for proper assessment and treatment were completed and no other resident was found to be affected by this practice.<br><br>3. Re-education of all staff to ensure that the resident receive proper treatment and assistive device to maintain visual abilities. MDS staff re-educated regarding accuracy of coding.<br><br>4. The nursing management team monitors the clinical record monthly. This information is presented at the quarterly QA Meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 313 | Continued From page 60 | F 313 | | |

The resident was observed an interview on 888, during breakfast on April 22, 2009 at approximately 9:00 AM and ambulating around the facility wearing his/her eye glasses.

Facility staff failed to promptly ensure that the resident received the assistive device ordered and needed to maintain vision.

A face-to-face interview was conducted on April 23 2009 at approximately 11:00 AM with Employee #11. After a review of the resident's record, he/she acknowledged the aforementioned findings. He/she stated that the resident's order for the eyeglasses was before he/she joined the facility and that he/she had since joining the facility accelerated ensuring that residents promptly obtain all appropriate, needed and ordered services and appointments. The record was reviewed April 23, 2009.

2. Facility staff failed to make an appointment to follow up with an impaired vision assessment and ensure proper treatment for Resident #12.

A review of Resident 12's clinical record revealed an admission Minimum Data Set (MDS) completed December 16, 2008 that coded the resident for impaired vision in Section D1(1) Vision Patterns.

The resident's clinical record lacked evidence that facility staff provided the resident with an ophthalmologist referral/consult and or appointment related to evaluate the assessed impaired.

A face-to-face interview was conducted with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 313 | Continued From page 61<br>Employee #28 on April 24, 2009 at approximately 11:00 AM. After a review of the resident's clinical record, he/she acknowledged that the resident's clinical record lacked evidence that the resident received an ophthalmologist referral/consult and or appointment to evaluate the assessed impaired vision. The record was reviewed April 24, 2009.<br><br>3. Facility staff failed to make appointment to follow up with an impaired vision assessment and ensure proper treatment for Resident #16.<br><br>A review of Resident #16's clinical record revealed an admission Minimum Data Set (MDS) completed September 27, 2008, that coded the resident for moderately impaired vision in Section D1 Vision Patterns.<br><br>The resident's clinical record lacked evidence that facility staff provided the resident with an ophthalmologist referral / consult and or appointment to evaluate the assessed moderately impaired vision.<br><br>A face-to-face interview was conducted with Employee #28 on April 24, 2009 at approximately 11:00 AM. After a review of the resident's clinical record, he/she acknowledged that the resident's clinical record lacked evidence that the resident received an ophthalmologist referral/consult and or appointment to evaluate the assessed impaired vision. The record was reviewed April 24, 2009. | F 313 | | |
| F 314 SS=G | 483.25(c) PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores | F 314 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 314 | Continued From page 62<br>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview for three (3) of 30 sampled residents and one (1) of 12 supplemental residents, it was determined that facility staff failed to monitor and treat one (1) resident ' s pressure ulcer of the right heel and maintain infection control practices during wound care treatments for three (3) residents. Residents #18, 1, 11 and S1.<br><br>The findings include:<br><br>1. Facility staff failed to monitor and treat Resident #18 ' s right heel ulcer.<br><br>On April 20, 2009 at approximately 10:10 AM a tour of unit 4 South was conducted. Employee #28 stated that there were two (2) residents with pressure ulcers on the Unit. Resident #18 was not included in the unit's pressure ulcer listing.<br><br>On April 22, 2009, Employee #28 was queried as to whether Resident #18 received dressing changes to the right heel since his/her name was not included on the Resident Sample Roster/Matrix (Form 802) with ulcers. Employee #28 responded, "The doctor discontinued the dressings. He/she has eschar to the heel. We are using a heel protector to protect the area and monitoring it." | F 314 | 1. Resident #18 was reassessed by the physician and the wound team. The hospital acquired area on the right heel has healed. Resident #1's hospital acquired pressure ulcer secondary to severe PVD is slowly healing. Resident #11's hospital acquired ulcer has resolved. The nursing staff has been re-instructed regarding wound technique and infection control for Resident #S1's chronic diabetic wound.<br><br>2. All residents with pressure sores were reassessed. Staff was instructed on wound dressing procedures and infection control practices.<br><br>3. The licensed nurses will be re-educated on how to monitor, measure and document weekly on the wound healing record, and on aseptic technique for wound care. The staff will also be re-educated on incontinent care<br><br>4. Monitoring of dressing change and documentation is conducted monthly. This information is presented at the Quality Assurance Committee meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING<br>B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 314 | Continued From page 63 | F 314 | | |

The quarterly MDS completed January 24, 2009, with an Assessment Reference Date (ARD) of January 14, 2009, was coded for a Stage II pressure ulcer under Section M1b. However, the same pressure ulcer was documented as unstageable in the Weekly Wound Healing Records dated December 31, 2008, January 7, 2009 and January 14, 2009. the employee and the surveyor agreed that the observation would be done at 9:00 AM on April 23, 2009.

An observation of the right heel was conducted on April 23, 2009 at 9:10 AM. He/she stated, "I was just informed by the nurse at 9:00 AM that the heel [right heel] has opened up. The covering that we were protecting has fallen off. I have already called the doctor and obtained an order for treatment."

During the wound observation at approximately 9:30 AM on April 23, 2009, Employee #28 removed a "heel- protector " from the resident's right heel and revealed an open area approximately 3 x 2 cm, covered with brownish/grey slough. No odor or drainage was noted from the wound. However, a soiled area was noted on the heel protector from drainage from the ulcer. The wound was open and without a dressing when observed.

According to the "Weekly Wound Healing Record" dated October 20, 2008, the resident was admitted to the facility with hospital acquired pressure ulcers of the right and left heels. On admission, the right heel ulcer was described as a Stage II pressure ulcer measuring 6 x 6 x 0.1 centimeters, with black/brown wound bed and surrounding skin. No drainage or odor was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 314 | Continued From page 64 | F 314 | | |

documented.

The right heel ulcer was described as follows: October 20, 2008: 6x6x0.1cm (size), no treatment documented, monitor until seen by wound Team, Stage II. (Comment)

According to the documentation on the Weekly Wound Healing Record, the Wound Team assessed the wound on October 22, 2008. On that day, the wound was recorded as a Stage II measuring 6x6x0.1cm and the treatment was documented as Silvadene with coversite for 7 days. The wound was documented weekly on the Weekly Wound Healing Sheets from October 22, 2008 through January 28, 2009.

Documentation on the physician's progress notes dated January 17, 2009 stated, "Patient seen by Wound Team. Left heel ulcer - healed. Rt. [right] heel eschar - monitor. Plan: D/C [discontinue] all wound Rx [prescription]. Continue pressure relief. We will sign off." The note was signed by the medical director. Another notation in the Physician's Progress note was dated March 18, 2009 at 3:00 PM documented: "Patient seen by Wound Team has Rt heel eschar poorly palpable pulses plan: pressure relief, air mattress... We will follow." This notation was also signed by the Medical Director.

No monitoring of the wound was noted on the clinical record from January 28 until March 18, 2009. The next documentation was made on April 23, 2009 when the area on the right heel was observed to be open. On April 23, 2009 the right heel ulcer was described on the Weekly Wound Healing Record as unstageable,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 314 | Continued From page 65<br>measuring 3x2x0.1 cm and with scant serous exudate.<br><br>The following documentation was noted on the physician's progress notes dated February 18, 2009. "Patient seen by Wound Team. Has excoriation on buttock area 2 [secondary to] incontinence/pressure healed?" This note was signed by the Medical Director. there was no documentation of an assessment of the right heel ulcer in this note and no further documentation from the Wound Team regarding the right heel ulcer until March 18, 2009.<br><br>A review of the Nurses' Notes failed to reveal documentation regarding the right heel ulcer from January 28 through April 23, 2009. On January 28, 2009 documentation on the Weekly Wound Healing Record documented the following:<br>Wound stage, unstageable.<br>Size and depth 0.<br>Exudate none.<br>Odor none.<br>Wound Bed Black/Brown<br>Surrounding Skin color Black Red/Purple<br>Surrounding Tissue/Wound Edges Normal for skin.<br><br>An entry in the nurses' notes dated April 23, 2009 at 10:45 AM documented the following: "CNA reported this AM at about 9AM the Rt [right] eschar on resident ' s foot had fallen off. Upon further assessment, resident's Rt heel revealed an unstageable pressure ulcer measuring 3 x 2 cm. [centimeters]. Wound bed is brown and there is minimal drainage. Peri wound is intact and the wound has no odor. MD aware and ordered treatment with Santyl ointment x 7 [seven] days. Resident's responsible party | F 314 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____<br>B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 314 | Continued From page 66<br>[name] made aware of the alteration in skin integrity at 10:30 AM. Will continue to monitor."<br><br>The facility failed to follow its Wound Care Protocol. On page 1 of 5 Section N of Policy NO. 104 Issued 01/05 in II Nursing Responsibility 3. is documented, "Weekly assessment and documentation using Altered Skin Integrity Assessment Form to include treatment done and all pertinent characteristics of the wound, and the drainage."<br><br>The record lacked documentation that the facility staff consistently monitored the resident's right heel from January 17, 2009, until April 23, 2009 when the right heel was observed to be open. The facility failed to follow its' Wound Care Protocol by performing and documenting Weekly assessments of Resident #18's right heel ulcer as outlined in the aforementioned policy.<br><br>At the time of this review the surveyor was not provided any additional documentation regarding Resident #18's right heel ulcer. However, at 4:33 PM on May 14, 2009 six (6) pages of information were received from the facility.<br><br>The first page was a report of a Bilateral Lower Extremity Arterial Ultrasound dated March 19, 2009. The impression of the report is documented below.<br>1. " Mild peripheral vascular disease within the right lower extremity as described above. The ankle-brachial index measured 0.78. This appears significantly improved since the prior study and clinical correlation is recommended.<br>2. Moderate peripheral vascular disease within the left lower extremity with an | F 314 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 314 | Continued From page 67 | F 314 | | |

ankle-brachial index of 0.74."

The second page was a report of a portable X-ray of the right heel. The impression of the X-ray is documented below.

"Negative Right Calcaneus without Erosions. No degenerative or unusual arthropathy. The soft tissues are normal without radiopaque foreign body. There is no plantar spur or erosions."

The third, fourth, fifth and sixth pages were copies of Weekly Wound Report for Unit Four South. The reports were dated March 18, April 1, April 8 and April 15, 2009. Each report had seven (7) columns. The columns were identified for Room [number], Resident [name], Current Treatment, Albumin level, Infection, E-Stim [electric stimulation] and Comment & F/U [Follow-Up]. The following information was noted on each report. The number of Resident #18's room, his/her name, ® Heel Eschar noted (under treatment) and Air Mattress under Comment and Follow-Up. A review of the forms did not reveal any additional information.

A Pressure Ulcer Listing for the facility was given to the Survey Team at approximately 3:00 PM on April 23, 2009. Resident # 18's ulcer was listed as a " Hospital Acquired ® Calcaneous unstageable secondary to eschar. "

The record was reviewed on April 23, 2009.

2. Resident #1 ' s to the right lateral foot was observed on April 22, 2009 at 10:10 AM and the following was observed: The aseptic technique was followed while removing the old dressing and cleaning the wound. However, after applying the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 314 | Continued From page 68<br>treatment cream Employee #12 was observed attempting to open the package of coversite when it fell on the floor next to the bed in Resident #1 ' s room. Employee #12 picked up the Covesite package opened the package and began shaking the dressing inside of the packet on to the clean field. After emptying the package, Employee #12 discarded the package into the red bag and proceed to wash his/her hands. Employee #12 applied the dressing to Resident #1 secured it with tape, removed his/her gloves washed his/her hands ...<br><br>Employee #12 failed to maintain a clean field when shaking the package of Coversite that had fallen of the floor and shook not only the content inside the package also what was on the outside of the package.<br><br>3. Facility staff failed to provide incontinent care to Resident #11 after a wound treatment.<br><br>During a wound treatment observation on April 27, 2009 at 11:00 AM, to Resident #11's sacrum, it was observed that Resident #11's diaper was wet when removed prior to the wound treatment. Employee #12 completed the wound treatment.<br><br>Employee #12 assisted by Employee #5 were observed applying a clean diaper after the wound treatment was completed without incontinent care.<br><br>A face-to-face interview was conducted on April 27, 2009 at 11:50AM with Employee #12 and #5. They stated, "The diaper was not really wet, just a little wet. That's why we didn't do incontinent care." This observation was conducted on April 27, 2009 at 11:25 AM. | F 314 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 314 | Continued From page 69 | F 314 | | |

Continued From page 69

4. Facility staff failed to follow clean technique for a wound treatment for Resident S1.

A review of Resident S1's record revealed a physician ' s order dated February 12, 2009 at 3:00 PM that directed, "Cleanse right plantar foot wound with Dermal wound cleanser. Apply Silvercel, 4 x 4 wrap with Kerlix q d (daily)."

A wound treatment observation was conducted on April 24, 2009 at 11:05 AM with Employee #20. The resident was supine on the bed. There was no dressing covering the wound prior to the dressing change. Employee #20 stated, " The wound is closed. We ' re doing this (treatment) until [Resident S1] returns to the [wound clinic]. "

Employee #20 failed to place a barrier under the resident ' s right foot prior to cleaning the wound. The wound was cleaned in an up and down fashion with Dermal wound cleanser sprayed onto a 4 x 4 gauze pad. Employee #20 opened and removed the sterile Silvercel dressing with the same gloved hands used to cleanse the wound. He/she pulled the dressing from the sterile package, returned the dressing into the sterile package, changed gloves, opened a 4 x 4 gauze pad package and placed the Silvercel dressing onto the 4 x 4 gauze pads and applied both to the plantar area of the right foot. Gloves were removed and Employee #20 wrapped Kerlix gauze around the resident ' s foot and secured with tape. Employee #20 then removed a pen from his/her pocket and wrote his/her initials, date and time on the tape on the resident.

The resident sat up on the bedside and walked to a chair a few feet away. There was no shoe or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 314 | Continued From page 70<br>sock on the resident ' s foot to cover the dressing. | F 314 | | |
| F 319<br>SS=D | 483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on staff interview and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to ensure that appropriate treatment and services were provided after verbal and/or physical altercations. Residents #13 and 23.<br><br>The findings include:<br><br>1. Facility staff failed to provide appropriate treatment after a physical altercation between Resident #13 and another resident.<br><br>A review of Resident #13 ' s record revealed a nurse ' s note dated October 7, 2008 at 7:30 PM, " Resident was sitting in hallway in front of the nurse ' s station when a male wheelchair resident ...backed into resident ' s chair. [Resident #13] turned around and started to hit the male resident ... "<br><br>According to care plan problem, #20 " Resident has physically abusive behavioral symptoms (others were hit, shoved, scratched). " Hand written under " Problems " was, " Resident scratched a male resident ... (who) bumped into | F 319 | 1. The record and recommendations for resident #13 was reviewed. Unable to retrospectively correct documentation from 2008; however an interdisciplinary care conference has been scheduled. The psychiatrist was contacted to ensure resident has been seen. Resident #23 was reassessed by the social work staff.<br><br>2. The Social work staff reviewed the Psychiatric/mental health/LICSW consult Sections of the chart to ensure the recommendations are reviewed for compliance and that behaviors are documented.<br><br>3. The Social Work staff will be re-educated regarding protocol for documentation and referrals for psychiatric consults and mental health services.<br><br>4. The Director of Social Services monitors the psychosocial needs of the residents monthly and to the QA committee quarterly. | 6/25/09 |

| (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 319 | Continued From page 71<br>[his/her] chair - 10/7/08. " Under approaches was the following hand written statement, " 10/7/08 - Psyc (psychiatric) consult for behavioral therapy. "<br><br>There was no evidence in the record that the psychiatrist had seen the resident as a result of the October 7, 2008 incident or interventions initiated for the above described behavior.<br><br>A social worker ' s note was written on October 20, 2008 and did not address the above cited incident.<br><br>A physician ' s progress note was written on November 10, 2008 and did not address the above cited incident.<br><br>The behavioral therapist saw the resident on February 2, 2009. According to the consult report, " [He/she] denied any additional incidents of aggression. " Recommendations included, " 1. Continue individual counseling to help with sadness and frustration as well as maintain mental status. 2. Day program or activity outside the facility. "<br><br>There was no evidence in the record that the behavioral therapist or social worker conducted regular counseling sessions or that a day program or activity outside the facility had been pursued by facility staff.<br><br>According to a nurse ' s note dated April 10, 2009 at 6:30 PM, " Received report from resident that when [he/she] was in the courtyard a male resident ...pulled on [Resident #13 ' s] clothes ... [Resident #13] scratched this male resident around his right eye and face. The skin was | F 319 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ___ B. WING ___ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 319 | Continued From page 72 broken with some slight swelling ... " <br><br> The primary medical physician prescribed Haldol 1 mg by mouth twice a day. <br><br> A face-to-face interview was conducted with Employee #8 on April 23, 2009 at 2:40 PM who acknowledged the above findings. The record was reviewed April 23, 2009. <br><br> 2. Facility staff failed to initiate interventions after two verbal altercations involving Resident #23. <br><br> A review of Resident #23 ' s record revealed a nurse ' s note dated January 23, 2009 at 1:00 PM, " Writer was made aware about the incident that happened in the gift shop on 1/10/09 between resident and gift shop director by social worker ...Writer asked resident what happened in the gift shop on above date between [him/her] and the man in the gift shop? Resident responded, " You don ' t ask me that shit no more if you want to talk about it you go and talk to somebody else and if you don ' t have something important to say don ' t come back ... " <br><br> The resident was seen on February 15, 2009 for an initial psychiatric evaluation. There was no evidence on the consultation report that the above episode was discussed. The recommendation directed that the resident continue taking the previously prescribed Cymbalta for depression. <br><br> A nurse ' s note dated March 5, 2009 at 1:20 PM documented, " Security reported [Resident #23] was verbally abusive to [him/her] using curse words. [The resident was] also verbally abusive to writer. " | F 319 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 319 | Continued From page 73<br><br>The social worker wrote a progress note on April 6, 2009 and did not address the March 5, 2009 incident.<br><br>There was no evidence that Resident #23 ' s behavior was reassessed, and that appropriate treatment and services were prescribed to correct the assessed problem.<br><br>A face-to-face interview with Employee #4 was conducted on April 24, 2009 at 12:00 PM. He/she acknowledged that the resident ' s behavior had not been reassessed with appropriate treatment initiated. The record was reviewed April 24, 2009. | F 319 | | |
| F 323 SS=G | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>1.Based on observations, staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to provide adequate supervision for: one (1) resident who exhibited unsafe wandering behavior with subsequent injury. Resident #20.<br><br>The findings include:<br><br>A. Facility staff failed to provide adequate supervision for Resident #20 who exhibited | F 323 | 1. Resident #20 was provided additional supervision which resulted in her assaulting the companion. The physician and psychiatrist have been contacted. The medication regime has been modified. All three (3) therapist completed a screen in January 2009.<br><br>The items identified during the environmental tour were removed, repaired secured and/or replaced.<br><br>2. The residents who exhibit wandering behavior will be reassessed for safety. A comprehensive inspection of the environment was conducted.<br><br>3. The program on the secure unit is being reviewed. A meeting was held by the Corporate Office with the staff on the secure unit specifically on training regarding the management of a secure unit. Management staff on secure unit have received training on program.<br><br>A meeting will be conducted with engineering/maintenance staff and nursing staff regarding the environment.<br><br>4. Monitoring of resident and documentation is a part of the comprehensive medical records audit. The Engineering Director and Supervisor monitors the facility for safety issues daily and includes work orders. Any concem identified is reported to the QA committee | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 74 | F 323 | | |

unsafe wandering behavior around the unit and into other resident's rooms and subsequently sustained injuries.

According to an annual Minimum Data Set (MDS) assessment completed on January 1, 2009, Section I (Disease Diagnoses) include: Alzheimer's disease, Dementia other than Alzheimer's disease, Depression, Manic Depression (Bipolar Disease), Schizophrenia and Cataracts.

A quarterly MDS completed on April 2, 2009, in Section B2 [Memory] coded Resident #20 as having short and long term memory loss. Section G [Physical Functioning and Structural Problems] coded the resident as requiring supervision with bed mobility, transfer and ambulation around the unit, extensive assistance with locomotion off the unit, limited assistance with one person assist when toileting, extensive assistance with dressing and personal hygiene, and total dependence with full staff performance for bathing and maintained position for test of balance with no range of motion limitation.

A review of the resident's clinical record revealed the following:
Nurses' notes:
January 3, 2009 at 2:30 AM, "Writer was summoned to the unit room ...and observed the resident sitting in a chair bleeding profusely from the left forehead and being attended by the charge nurse and a CNA (Certified Nursing Assistant). Writer was informed that the resident had allegedly wandered into room ...., and that one of the male occupants had allegedly pushed the resident and the resident fell to the floor striking the head and sustaining a laceration to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 323 | Continued From page 75<br>the left forehead ...laceration measures 2.5 cm x 2 cm with some depth ...hematoma noted and some continuous bleeding. Resident remained responsive to name and tactile stimuli ...however unable to or unwilling to explain this occurrence. Attending physician notified and order received to transfer resident to E.R. (Emergency Department) via 911 ...Transfer resident to stretcher and left the facility en route to ...hospital."<br><br>March 8, 2009 at 3:20 AM: "At about 9:30 AM writer observed from a distance as another resident pushed [resident] to the floor. [Resident] fell and sustained a laceration on ... Lt. (left) eyebrow measuring 3 cm ...Supervisor and MD (Medical doctor) made aware. MD ordered neuro checks x 48 hours, PT/OT/Rehab consult and transfer the resident to the nearest ER for application of sutures and to R/O (Rule out) head injury ...Resident was transferred to [hospital]."<br><br>March 8, 2009 at 9:00 PM "Resident returned to unit. Laceration on left eyebrow tx. (treated) dermaband wound care. No drainage, or swelling, redness noted ...Responsible party ...made aware of return to facility."<br><br>Further review of the resident's clinical record revealed the following interim orders:<br>Telephone orders:<br><br>"March 8, 2009 at 9:36 AM: PT/OT [Physical therapist/Occupational therapist] rehab consult S/P fall of 3/8/09 "<br>"March 10, 2009 at 11:45 AM: (1) ST [Speech Therapist] to evaluate and tx. [treat] as indicated.<br><br>(2) ST clarification: ST 5X 1 week x 60 days in group and individual settings for symbolic | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 76 | F 323 | | |

dysfunction (784.69) for safety, orientation and caregiver training."

According to " Physician ' s Order " sheet for March 2009 dated and signed by the physician on March 4, 2009, the resident ' s medication included:
"Benztropine 2mg 1 tablet by mouth twice daily for EPS [Extrapyramidal symptom] "
"Clonazepam 1mg 1 tablet by mouth twice daily for agitation."
"Paroxitine 30 mg 1 tablet by mouth every evening for depression."
"Lorazepam 1 mg 1 tablet by mouth every 6 hours as needed for agitation."

The resident was seen for rehabilitation screening on January 5 and March 8, 2009 as a follow up to the fall incidents of January 4, and March 8, 2009 as evidenced by the entries on the "Therapy Screen Form."

According to the screen forms signed and dated by the physical, occupational and speech therapist on January 5, and March 9, 2009, therapy evaluation was not indicated for OT/PT
and ST functional deficits. PT screen was not performed during the January 2009 screen.

A further review of the resident's rehab visit revealed a "Speech language pathology plan of care for rehabilitation" with short term goals that included: "ST will educate and provide training to care givers re: supporting resident's problem solving and safety awareness. D/C [Discharge for max ...potential for increased quality of life." Under the evaluation of "Goals met?" The ST noted: "No" "Pt. [Patient] unable to tolerate tx. at present, development of adaptive strategies

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 77<br>inappropriate at present."<br><br>A review of the resident ' s clinical record revealed an "Interdisciplinary Care Plan" initiated January 4, 2009 with that included:<br><br>Short term goals "Resident will wander safely within specified boundaries and will not negatively impact self or others x 90 days."<br><br>Approach: "Establish consistent limits on behavior and communicate clearly on these limits. Post signs or devices to prevent resident from other resident ' s space." [Door strip alarm in-service was provided to a certified nursing assistant and a licensed practical nurse on February 27, 2009].<br><br>The aforementioned care plan was updated on March 9, 2009 with the following new approaches:<br><br>"Resident will be assigned volunteers to work with [him/her] and prevent being pushed by another resident. Staff will monitor resident by staying in the room when [he/she] resists to be moved from another resident's room."<br><br>A wandering care plan was updated in March 8, 2009 with the following new approach: "Resident assigned a volunteer for closer monitoring."<br><br>On April 20, 2009 at approximately 10:45 AM, Resident #20 was observed during the initial tour of the facility. He/she was wearing two different types of footwear; a black shoe with approximately half (1/2) inch high and a white flat bedroom slippers and had an unsteady gait.<br><br>On April 23, 2009 at approximately 3:30 AM, the | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 78 | F 323 | | |

resident was observed wearing two different types of sneakers, both unlaced, with an unsteady gait, walking out of another resident ' s room, accompanied by Employee # 33. Employee # 33 said, "I just got the resident out of [male resident] room, where I found [Resident #20] laying in bed."

On April 24, 2009 at approximately 9:40 AM, the resident was observed ambulating around the unit. He/she was observed wearing a pair of unlaced sneakers with the top flap not tucked inside the sneakers, accompanied by Employee # 34.

When asked if it was safe for the resident to walk with unlaced sneakers, Employee # 34 responded, "It's not safe, but the resident puts shoes on and changes them frequently throughout the day. He/she takes other residents' stuff including their shoes and puts them in [his/her] room." 10 pairs of shoes belonging to unidentifiable residents were observed at the time of this observation in Resident # 20's room.

The resident was observed on April 24, 2009 at approximately 10:30 AM ambulating alone around the unit. Resident A5 was seated in a wheelchair, watching television in the dayroom with his/her back to the nursing station. Resident A5 shouted to Employee #16, who was in the day room with other residents, for help as Resident #20 took the fire extinguisher by the nursing station off from the wall.

On April 27, 2009 at approximately 2:30 PM, the resident was observed asleep in his/her bed. Employee #35 was seated at the resident's bedside. Employee #35 said, "I'm here twice a week. I help around the unit and have been

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 79 | F 323 | | |

assigned to [Resident #20]. When I am here, I walk the resident around the unit, the facility and the courtyard. I redirect the resident when [he/she] wanders into other resident rooms and attempts to take their things"

Facility staff failed to provide adequate supervision for Resident # 20 who has exhibited unsafe wandering behavior around the unit and into other resident's rooms and subsequently sustained injuries.

According to the interdisciplinary care plan initiated on January 4, 3009, one approach is "A post sign or device to prevent the resident from other resident's space. The device, a "Door strip Alarm" was observed in place at the entry to [room #...] only. The device at the entry of one room failed to provide adequate deterrent to the resident's disruptive, annoying, unsafe wandering, restlessness and repetitive behaviors, taking other residents' items, going into other residents' rooms, and laying in other resident's beds. While the resident according to the care plan is "Oblivious to needs or safety" and was non-aggressive, his/her behavior precipitated a negative response from others such as the negative response from the residents who pushed him/her on January 3, and March 8, 2009 both with injuries.

The resident's clinical record lacked evidence that ST provided education and training to care givers to support the resident's problem solving and safety awareness as indicated in the ST plan of care.

A face-to-face interview was conducted on April 27, 2009 at approximately 10:33 AM with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ___ B. WING ___ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 80<br>Employee #36. He/she stated, "We currently have a volunteer work two days a week with the resident 1:1, but I am afraid we will not be able to provide a continuous 1:1 supervision. I will be sad to have to discharge [him/her] from our facility as [his/her] need will be beyond what we can provide if [he/she] is a danger to [him/herself] and others and will need a continuous 1:1 to keep [him/her] safe." The record was reviewed April 27, 2009.<br><br>2. Based on observations during the environmental tour, it was determined that the facility staff failed to maintain a hazard free environment as evidenced by: eight (8) of eight (8) unmounted multiplugs, one (1) of one (1) protruding metal mount in the 2S shower room, two (2) of eight (8) damaged depress buttons to water fountains, one (1) of one (1) oxygen canister not in a holder, laundry products stored unlocked in one (1) of 50 resident rooms, one (1) of eight (8) TV eye guards missing in the day rooms, one (1) of eight (8) suction machines not readily accessible for emergencies, one (1) of one (1) door to the gift shop corridor with a sharp edged strip, two (2) of two (2) bathrooms for dietary staff with a portion of the ceiling missing, and one (1) of one (1) cracked mirror in beauty shop.<br><br>These findings were observed during the environmental tour which was conducted on April 20, 2009 from 12:30 PM through 4:30 PM and April 21, 2009 from 8:30 AM through 12:45 PM in the presence of Employees #21 and 22 who acknowledged the findings at the time of the observations.<br><br>The findings include: | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 81<br>A. Multiplugs were observed on the floor and not mounted on the wall in the following areas: rooms 117, 217, 234, 300, 3N day room, 402, 423 and 4S computer lounge in eight (8) of eight (8) unmounted multiplugs.<br><br>B. The grab bar was removed from the 2S shower. However, the metal mounts remained on the wall and protruded approximately two (2) inches from the wall directly in the space where the resident would sit to take a shower in one (1) of 24 shower rooms observe.<br><br>C. The depress buttons for the water fountains on 2N and 4S were damaged with rough edges in two (2) of eight (8) water fountains observed.<br><br>D. An oxygen canister in room 423 was not secured in a holder to prevent accidental tip over in one (1) of one (1) unsecured oxygen canister observed.<br><br>E. Non-chlorine bleach and Purex laundry detergent was observed unsecured on the floor of room 423 in one (1) of 50 resident rooms observed.<br><br>F. The eye guard to the TV in the 4N day room was missing in one (1) of eight (8) televisions observed in day rooms.<br><br>G. The suction machine for emergency use on 4N was located in a corner of the clean utility room between a mobile laundry cart and a stationary set of storage shelves. The laundry cart required moving out of the clean utility room before the suction machine was accessible in one (1) of eight (8) suction machines observed. | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 323 | Continued From page 82<br>H. The door to the gift shop corridor was observed with a sharp edged, unsecured strip along the exterior side of the door. Residents, staff and visitors passed this door to gain access to the gift shop in one (1) of one (1) door to the gift shop corridor observed.<br><br>I. A portion of the ceiling in the men ' s and ladies bathrooms on the basement floor used by the dietary staff had been removed in two (2) two (2) bathrooms for dietary staff observed.<br><br>J. The beauty shop mirror was observed cracked and the cracked portion had jagged edges and could be felt in one (1) of one (1) beauty shop mirror observed. | F 323 | | |
| F 329 SS=D | 483.25(l) UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | F 329 | 1. The lab was contacted regarding Resident #16, and the completed laboratory report have been placed in the clinical records. Resident #17 was appropriately medicated with Tylenol for pain. Unable to retrospectively document reasons and effectiveness of Tylenol. Resident #30 is a closed record.<br><br>2. A review of lab request, Tylenol and Ambien usage for t he last quarter was completed. No other resident was impacted by this practice.<br><br>3. The licensed staff will be re-educated on implementation of physicians orders, and documentation of medications. The medical record/unit clerk staffing has been increased.<br><br>4. Monthly medical records audits are conducted. This information is presented at the quarterly QA. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 329 | Continued From page 83<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for three (3) of 30 sampled residents, it was determined that the facility failed to monitor one (1) resident for the use of Dilantin, and inadequate indications for the use of medications for two (2) residents. Residents #16, 17, and 30.<br><br>The findings include:<br><br>1. Facility staff failed to monitor Dilantin levels as per physician's order for Resident #16.<br><br>A review of Resident #16's clinical record revealed "Physician's Order" sheets signed and dated June 26, September 26, and November 21, 2008 and January 23, and April 3, 2009 that directed,"Dilantin level every month." The order was initiated on February 9, 2007.<br><br>According to the Medication Administration Record (MAR) for June 2008 through April 2009, the resident received Dilantin 100 mg twice daily.<br><br>According to the resident's "Physician's Progress Notes", the resident was seen by the physician on the following dates: May 23, July 25, September 26, and November 21, 2008, January 9 and 23, March 21, and April 3, 2009<br>.<br>There were no monthly Dilantin levels in the resident's record from May 2008 through the time of this review. | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 329 | Continued From page 84 | F 329 | | |

There was no evidence that the physician requested the results of the monthly Dilantin levels from May 2008 through the time of this review.

A face-to-face interview was conducted with Employee #28 on April 27, 2009, at approximately 10:10 AM. After reviewing the resident's clinical record, Employee #28 acknowledged that there were no monthly Dilantin levels from May 2008 through April 2009. The record was reviewed April 27, 2009.

2. Facility staff administered Tylenol to Resident #17 without adequate indication for its use.

A review of Resident #17's record revealed a physician' s order dated December 23, 2008 at 8:45 PM, directed, " Tylenol 650 mg po q (every) 8 hours PRN (as needed) for pain."

According to the Medication Administration Record (MAR) for February 2009, the resident received Tylenol on February 4, 5, 7 and 8, 2009, no time indicated. The back of the MAR included the following instructions: " When PRNs are given, explain in nurse' s notes." The back of MAR was blank and lacked the date, time, administering nurse' s initials and comments regarding the above cited four (4) doses of Tylenol.

A review of the nurses' notes for February 4, 5, 7 and 8, 2009, revealed no explanation for the administration of the Tylenol.

A face-to-face interview with Employee #12 was conducted on April 24, 2009 at 8:15 AM. He/she

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 329 | Continued From page 85 | F 329 | | |

acknowledged that there was no indication for the use of Tylenol. The record was reviewed April 23, 2009.

3. Facility staff failed to indicate adequate use for Ambien for Resident #30 a closed record.

The resident was admitted to the facility on August 1, 2008, was hospitalized on April 7, 2009 and discharged from the facility on April 13, 2009.

According to the admission orders dated August 1, 2008, the resident was prescribed Ambien 5 mg at bedtime for insomnia. The order was renewed September 30, October 28, November 25, 2008 and January 16, 2009. The resident was hospitalized from February 15 through 26, 2009. The Ambien was not reordered when the resident returned to the facility.

A review of the MARs for August, September, October, November and December 2008 and January 2009 revealed that the resident was never administered Ambien.

The admission Minimum Data Set assessment completed August 12, 2008 did not code the resident in Section I (Disease Diagnoses) for insomnia. Disease diagnoses included on the admission history and physical examination completed by the physician on August 12, 2008 did not include insomnia.

A face-to-face interview was conducted with Employee #26 on April 24, 2009 at 5:00 PM. He/she acknowledged that there was inadequate indication for the use of Ambien. The record was reviewed April 24, 2009.

| F 334 | 483.25(n) INFLUENZA AND PNEUMOCOCCAL | F 334 | | |
|---|---|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 334<br>SS=E | Continued From page 86<br>IMMUNIZATION<br><br>The facility must develop policies and procedures that ensure that –<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that –<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has | F 334 | 1. The immunization records for residents #1,3,4,5,6,10,11,13,14,15,17,21,22,25 and 27 were conducted. We cannot retrospectively administer influenza vaccine to residents #4,5 and 6; however, resident #'s 1,3,5,6,10,13,14,15 and 25 have received pneumococcal vaccine. Resident #'s 4,11, and 22 refused immunization and pheumoccocal vaccine. Resident #27 is no longer in the facility.<br><br>2. All residents chart were reviewed for documentation that the influenza and or pneumococcal vaccines had been administered and or refused by resident.<br><br>3. All licensed nurses will be re-educated on ensuring consistent documentation of influenza and or pneumococcal, administration or refusal by residents.<br><br>4. Review of all charts on documentation of influenza and or pneumococcal vaccine administration or refusal will be monitored using vaccination log and reported monthly to QA. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 334 | Continued From page 87 already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review, staff interview and review of facility policy for 15 of 30 sampled residents, it was determined that the facility staff failed to ensure that the resident's medical record included documentation that indicated that 15 residents did not receive the influenza and/or the pneumococcal immunization due to the residents refusal. Residents #1, 3, 4, 5, 6, 10, 11, 13, 14, 15, 17, 21, 22, 25 and 27.<br><br>The findings include: | F 334 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ___<br>B. WING ___ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 334 | Continued From page 88<br><br>On April 27, 2009 at 10:30 AM, a review of the line listing identifying all residents in the facility that received and/or refused the influenza and/or the pneumococcal immunization was conducted and revealed that there was no information regarding the administration of influenza and/or pneumococcal immunizations for the following residents: Resident's #1, 3, 4, 5, 6, 10, 11, 13, 14, 15, 17, 21, 22, 25 and 27.<br><br>The clinical records were reviewed for the aforementioned residents. According to Employee #2, the resident's consent for the Influenza vaccine should have been in the clinical record. However, the Influenza Vaccine Administration Record, Medication Administration Record and the nurses' progress notes lacked documented evidence that the vaccine(s) were administered by staff and/or refused by the resident.<br><br>On April 27, 2009 at approximately 10:30 AM a face-to-face interview was conducted with Employees #1, 2 and 26. They presented the line listing and acknowledged that the clinical records did not consistently contain documentation that the influenza and/or pneumococcal vaccines had been administered and/or refused by residents. | F 334 | | |
| F 364<br>SS=D | 483.35(d)(1)-(2) FOOD<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced | F 364 | 1. The temperature reading of both pancakes and grits was corrected immediately by increasing the hot water in the steam table.<br><br>2. The Dietary manager rechecked all hot food temperatures at the beginning, midway and end of the meal service tray lines.<br><br>3.The dietary staff will be re-educated on Food handling, food temperature monitoring and proper usage of the steam table.<br><br>4. Daily food temperature log is conducted and will be included in the dietary monthly QA report. This information will be presented to the quarterly QA committee. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 364 | Continued From page 89<br>by:<br>Based on observations during the inspection of the main kitchen, it was determined that facility staff failed to maintain food on the tray line at the proper temperatures.<br><br>The findings include:<br><br>An observation of the tray line was conducted on April 20, 2009 at 8:40 AM. Holding temperatures of the food were measured by Employee #30. The temperature of both the pancakes and grits was 110 degrees Fahrenheit (F).<br><br>A face-to-face interview was conducted with Employee #30 at the time of the observation. He/she stated, " We need more water in the steam table to keep the temperature up. 110 degrees is too low. It should be 140 degrees. " | F 364 | | |
| F 371 SS=F | 483.35(i) SANITARY CONDITIONS<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations during the tour of the main kitchen and the emergency food storage area conducted on April 20, 2009 from 8:40 AM through 12:15 PM, it was determined that facility staff failed to store, prepare, distribute and serve | F 371 | 1. A drain company has been contacted regarding the drains. (without air gaps) A needs assessment will be provided. The Soiled items identified in the survey have been re-cleaned. The knobs for turning gas supply on/off have been replaced; and a stopper was obtained for the three compartment sink.<br><br>All food items identified during the survey were discarded immediately. The dented cans were moved to the existing dented can cart. No resident was affected by this practice.<br><br>2. A comprehensive inspection was conducted of all the drains in both the kitchen and dish room. Food items sited during the survey were discarded immediately. All foods stored in the walk-in refrigerators and freezer were inspected thoroughly for spoilage, and expiration dates. All expired and outdated food including peanut butter was discarded immediately.<br><br>3. The Engineering Department will include drains on the preventative maintenance schedule. The Dietary Staff were re-educated on the storage preparation, distribution and serving food.<br><br>4. The Director of Engineering and Dietary Departments will increase the monitoring and surveillance of the kitchen. It will be reported to the quarterly QA committee. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW**<br>**WASHINGTON, DC 20001** |

| (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 371 | Continued From page 90<br>food under sanitary conditions as evidenced by: observations in the main kitchen included insufficient air gap for three (3) of three (3) backflow pipes, soiled exterior of three (3) of three (3) tubs with handles, two (2) of two (2) pipes to equipment between ovens and steam kettle, one (1) of one (1) drain in front of steam kettle, two (2) of two (2) floors in the kitchen and dry storage area, the exterior of two (2) of two (2) storage bins, six (6) of eight (8) filters over the gas oven; one (1) of six (6) knobs missing on the gas stove, and stopper missing for one (1) of the three (3) compartment sinks.<br><br>Observations of the walk-in refrigerator included the following: furry and/or mushy soft brown spots on 42 of 87 tomatoes, five (5) of five (5) cantaloupe, one (1) of one (1) case of yellow squash and 30 of 30 apples.<br><br>Opened and undated food observed in the walk-in refrigerator included: 1 ½ (one and one-half) bags of iceberg lettuce, one (1) of one (1) bag of parsley and one (1) of one (1) 5-pound bag of carrots.<br><br>Foods stored longer than seven (7) days included: one (1) of one (1) container each of tomato paste, pickles, cranberry sauce, okra, and chopped tomatoes in five (5) of five (5)containers observed.<br><br>The following items were observed undated in the freezer: eight (8) of eight (8) containers of juice, one (1) of one (1) 5-gallon container of vanilla ice cream, one (1) of one (1) package of non-dairy topping, one (1) of two (2) containers of red fruit punch, one (1) of one (1) package of pork rib patties, and one (1) of one (1) package of pork | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 371 | Continued From page 91<br>sausages.<br><br>Expired food stuffs, dented cans in current stock and undated products were observed in dry storage and the emergency food storage area as follows: in the dry storage area observations included: two (2) of six (6) dented cans in current stock; no expiration date for seven (7) of seven (7) bags of brown sugar, 10 of 10 boxes of frosting, 11 of 11 boxes of yellow corn meal, and five (5) of five (5) packages of corn meal stuffing.<br><br>Observations in the emergency food storage area: one (1) of one (1) dented can of corned beef, two (2) of four (4) cases of cereal with expiration dates of April 6 and 10, 2009, and 50 of 50 packets of Swiss Miss chocolate mix with an expiration date of April 6, 2009.<br><br>Three (3) of three (3) cases of peanut butter were not marked to indicate the stock should not be used in the dry storage and emergency food storage area.<br><br>Cases of canned goods such as pureed turkey, assorted vegetables, lemon pudding, sliced apples, applesauce and mixed fruit were observed undated in both dry storage and the emergency food storage area.<br><br>178 of 231 breakfast, lunch and dinner trays were delivered after the facility identified delivery time.<br><br>The kitchen tour was conducted in the presence of Employee #24 who acknowledged the findings at the time of the observations.<br><br>The findings include: | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 371 | Continued From page 92<br>Observations in the main kitchen included the following:<br><br>1. Drains failed to have an air gap to separate a water supply outlet from potentially contaminated sources:<br>One (1) drain located in the cook' s preparation area,<br>One (1) drain in the pot and pan wash area<br>One (1) drain in the salad preparation area in three (3) of three (3) drains observed.<br><br>2. The following items were observed soiled:<br>Three (3) of three (3) stainless steel tubs with handles.<br>Two (2) of two (2) pipes to the kitchen equipment between the ovens and the steam kettle areas.<br>Floor under the steam kettle, by the pot and pan wash area, in the walk-in produce refrigerator, in the freezer and in the dry storage area in five (5) of seven (7) areas observed.<br>The exterior surfaces of the flour and rice bins in two (2) of two (2) bins observed.<br>Six (6) of eight (8) filters located above the gas stove.<br><br>3. One (1) of six (6) knobs used to turn on the gas supply to the burners was missing.<br><br>4. One (1) of the three (3) compartment sinks was missing a stopper. A white plastic cup lid was being used as a drain stopper.<br><br>5. Observations of the walk-in refrigerator included the following observations:<br><br>White and black spots on 42 of 87 tomatoes.<br>Dark brown, soft spots on the exterior of five (5) of five (5) cantaloupes. | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 371 | Continued From page 93<br>Fuzzy white growth on the exterior of yellow squash in one (1) of one (1) case.<br>Soft, mushy brown spots on 30 of 30 apples.<br><br>B. Opened and undated foods were observed in the walk-in refrigerator:<br>One and one-half (1 ½ ) bags of iceberg lettuce.<br>One (1) of one (1) bag of parsley.<br>One (1) of one (1) 5-pound bag of carrots.<br><br>C. Foods stored longer than seven (7) days included:<br>One (1) of one (1) container of tomato paste dated April 10, 2009.<br>One (1) of one (1) container of pickles dated April 6, 2009.<br>One (1) of one (1) container of pickles dated April 9, 2009.<br>One (1) of one (1) cranberry sauce dated April 7, 2009.<br>One (1) of one (1) container of okra dated April 6, 2009.<br>One (1) of one (1) container of chopped tomatoes dated April 9, 2009.<br><br>6. The following items were observed undated and/or unlabelled in the freezer:<br>Eight (8) of eight (8) containers of juice.<br>One (1) 5-gallon container of vanilla ice cream.<br>One (1) of one (1) package of non-dairy topping.<br>One (1) of two (2) containers of red fruit punch.<br>One (1) of one (1) package of pork rib patties.<br>One (1) of one (1) package of pork sausages.<br><br>6. Expired food stuffs, undated products in dry storage and the emergency food storage area and dented cans in current stock were observed as follows: | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 371 | Continued From page 94<br>In the dry storage area, one (1) partial case of unsalted saltines had a shipping date of March 9, 2009 and one (1) partial case of regular saltines had a shipping date March 26, 2009. There was no expiration date for either product. However, the crackers were fresh when tested.<br><br>The following were observed in the dry storage area with no expiration date:<br>Seven (7) of seven (7) 2 pound-bags of brown sugar<br>10 of 10 boxes of frosting<br>11 of 11 boxes of yellow com meal<br>Five (5) of five (5) packages of corn meal stuffing<br><br>The following were observed in the emergency food storage area:<br>One (1) case (12 boxes) of 16 ounce Rice Crispies had an expiration date of April 6, 2009.<br>One (1) case of 16 ounce Raisin Bran had an expiration date of April 10, 2009.<br>50 packets of Swiss Miss chocolate mix had an expiration date of April 6, 2009.<br><br>Cases of canned goods such as pureed turkey, assorted vegetables, lemon pudding, sliced apples, applesauce and assorted fruit were observed undated in both dry storage and the emergency food storage area. A date code was stamped on the top of the cans. At the time of the inspection, facility staff was unable to interpret the date code.<br><br>Employee #24 contacted the supplier on April 20, 2009 and received directions for date code interpretation. However, all products stored in dry storage and the emergency food storage areas were not included on the brand name list of " How to Read Our Manufacturing Code." | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 371 | Continued From page 95 | F 371 | | |

Dented cans were observed in the following current stock in the dry storage area:

One (1) of three (3) 6# (pound) can of pineapple tidbits
One (1) of three (3) 6# can of mandarin oranges

One (1) 6# can of corn beef hash was dented when observations were made in the emergency food storage area. The total number of cans of corn beef was not visible because of the way the food products were stored.

At the time of these observations, Employee #24 was queried regarding the system used to stock products in the dry storage area and the emergency food area. Employee #24 stated, " We use first in and first out. The older products are pulled towards the front and the newer products are placed in the back. Only one employee, the assistant manager and I stock the shelves. I have instructed everyone else that product must be taken from the front of the row and not the back."

On April 21, 2009 at 8:00 AM, Employee #30 was asked how his/she pulled products out of dry storage for use. Asked to gather items for a pineapple gelatin salad, Employee #30 retrieved gelatin mix. He/she then walked over to the can goods storage area and retrieved a can of pineapple tidbits. Three (3) cans of pineapple tidbits were lined up on the end of the canned goods storage rack and were accessible through the side as well as the front of the rack. Employee #30 pulled a can of pineapple tidbits from the back of the row.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 371 | Continued From page 96<br>Facility staff failed to develop a system to ensure that dry storage items were used on a "first in first out" basis and remove expired items from current stock.<br><br>4. Two (2) of two (2) cases of peanut butter were stored in the dry storage area and one (1) of one (1) case of peanut butter in the emergency food storage area were observed. Employee #24 stated at the time of the observation, "We are waiting for FDA to approve the use of this peanut butter. It' s not being used right now." The peanut butter was not marked to indicate that it should not be used.<br><br>5. According to the " Tray Delivery and Nourishment Acceptance Log" 178 of 231 breakfast, lunch and dinner trays from April 11 through 15, 2009 and April 17 through 21, 2009 (April 16, 2009 log sheet could not be located at the time of this review) were delivered after the scheduled delivery times as follows:<br><br>1 to 15 minutes late: 50<br>16 to 30 minutes late: 61<br>31 to 45 minutes late: 41<br>46 to 60 minutes late: 14<br>More than 60 minutes late: 12<br>1 hour 2 minutes<br>1 hour 3 minutes<br>1 hour 5 minutes<br>1 hour 15 minutes (two times)<br>1 hour 27 minutes<br>1 hour 35 minutes (two times)<br>1 hour 45 minutes<br>1 hour 55 minutes<br>2 hours 20 minutes<br>2 hours 25 minutes | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 371 | Continued From page 97<br>Employee #24 acknowledged all of the above findings at the time of the observations. | F 371 | | |
| F 386 SS=D | 483.40(b) PHYSICIAN VISITS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on staff interview and record review for four (4) of 30 sampled residents and one (1) of 12 supplemental residents, it was determined that the physician failed to review the total plan of care for: two (2) residents for weight loss, one (1) resident with an order for eye glasses, one (1) resident with left ankle pressure ulcer, and one (1) for follow-up on positive findings of a breast exam. Residents #1, 4, 5, 16, and F1.<br><br>The findings include:<br><br>1. The physician failed to address Resident #1's change in weight.<br><br>The "Monthly Weight and Vital Signs Record" Year 2008 revealed,<br>"September 9/2/08 Weight 123 [pounds], Reweight 9/18/08-155 [pounds];<br>October 10/16/08 Weight 113 [pounds];<br>November 113 [pounds]; January 1, 2009 weight =100.5." | F 386 | 1. Resident #1's weight loss was attributed to the recommended above the knee amputation (AKA). Resident #4 has obtained her eye glasses, however she refuses to wear as prescribed. Resident #5 weight loss was secondary to Dysphagia. However, peg placement was done as per MD's order. Resident #16 wound is being monitoring by the wound team including the Medical Director weekly. Resident # F1 no longer resides in this facility. The medical documentation cannot be retrospectively corrected.<br><br>2. The physician documentation including a review of physician's plan of care is done by physician during the rounds.<br><br>3. Medical staff were educated during Medical Staff Meeting on May 27, 2009. Licensed nurse manager were also present at this meeting.<br><br>4. Quarterly reviews by Medical Director are reported at QA meetings. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 386 | Continued From page 98 | F 386 | | |

According to the clinical record the Resident's readmission weight was 113 [pounds] on October 16, 2008.

The clinical record reflected that Resident #1 lost 42 pounds between September 25, 2008 and October 16, 2008 [21 days].

Review of the physician's progress notes dated October 27 and November 17, 2008, and January 5, 2009 revealed, " ...Weight _ [left blank], Change: _ +/- [left blank] ... "

The physician's progress notes lacked evidence that the resident's weight loss was address at the time of his/her review.

A face-to-face interview was conducted on April 23, 2009 at 2:30 PM with Employee #17. He/she acknowledged that the physician did not address the Resident #1's weight loss during his/her review of plan of care. The record was reviewed on April 23, 2009.

2. The physician failed to review the total plan of care as evidenced by failure to follow up with his / her order for an eye glasses to maintain vision for Resident # 4.

A review of Resident 4's record revealed that the physician visited the resident on May 23, June 26, July 24, September 22, and November 26, 2008, and March 23, 2009.

A review of the resident's clinical record revealed the following nurses' note "7/31/08 at 3:00 PM Resident alert and verbally responsive...Left the unit with escort at 10:30 AM for eye appointment

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 386 | Continued From page 99 | F 386 | | |

at [...hospital] with [Dr ...] Returned at 2:20 PM with recommendation that the Resident request for eye glasses. Consult given to unit clerk to make the eye [Eye glasses] fitting appointment. F/U [Follow up] eye check in 6 month. MD made aware ..."

A further review of resident # 4's record revealed a physician's "Interim Order Form" dated July 31, 2008 and signed by the physician on September 5, 2008 that directed: (1) " Schedule eye [Eye glasses] fitting appointment, (2) f/u (Follow-up) eye check in 6 months, due January '09.

"April 1, 2009 4:00 PM Resident left the unit at 9:00 AM for eye fitting appt. [Appointment] at [ ...Hospital]. Returned at 11:00 AM. Eye [Eye glasses] fitting done, awaiting
eye glasses ... "

There was no evidence in the resident's clinical record that the physician followed up with the resident's order for eye glasses after the interim order of July 31, 2008.

A face-to-face interview was conducted with Employee #11 on April 23, 2009 at approximately 11:00 AM. After reviewing the resident's clinical record, he/she acknowledged that the physician's progress notes failed to address the resident's vision and follow-up with his / her order for eyeglasses. The record was reviewed April 23, 2009.

3. The physician failed to address Resident #5's change in weight.

The " Monthly Weight and Vital Signs Record " Year 2008 revealed, " ... August 27, 2008 [per

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 386 | Continued From page 100<br>facility the aforementioned dated is the September 2008] Weight 136 [pounds] and October 10/7/08 Weight 114.5 [pounds ... "<br><br>According to the clinical record the Resident ' s readmission weight =114.5 [pounds] on October 10/7/08.<br><br>The clinical record reflects that Resident #5 lost 21.5 pounds between August 27, 2008 and October 7, 2008.<br><br>Review of the Attending notes dated October 27, 2008, November 17, 2008, January 5, 2009 revealed, " ...Weight _ [left blank], Change: _+/- [left blank] ... "<br><br>The attending notes lacked evidence that the Resident ' s weight loss was address at the time of his/her review on October 20, 2008 review.<br><br>A face-to-face interview was conducted on April 21, 2009 at 10:30 AM with Employee # 12. He/she acknowledged that the physician did not address the Resident #5 ' s weight loss during his/her review of plan of care. The record was reviewed on April 21, 2009.<br><br>4. The facility physician failed to follow-up with Resident #16's left ankle pressure ulcer.<br><br>A review of the resident's clinical record revealed the following nurses' notes:<br><br>"March 30, 2009 at 7:00 AM: Resident noted with a re-open area on the Lt. (Left) malleolus. Resident scratches area. Finger nails trimmed short, re-open area was cleansed with NSS (Normal Saline Solution), pat dry, applied | F 386 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 386 | Continued From page 101 | F 386 | | |

Neosporin, a 4 x 4 taped until seen by wound doctor."

"April 3, 2009 at 11:00 PM: "Resident was noted with left ankle open area this shift. MD (Medical Doctor) was made aware and treatment order was given until further evaluation by wound team. RP was also notified. Ankle wound measures 1.2 cm x 1 cm."

A further review of the resident's clinical record revealed the following "Physician's Progress Notes":

April 3, 2009 "Attending Periodic Note: No significant interval history...A/P (Assessment / Plan): continue management as per order reviewed and signed by me."

The physician's note of April 3, 2009 lacked evidence that the physician addressed the resident's left ankle pressure ulcer.

A face-to-face interview was conducted with Employee #28 on April 27, 2009 at approximately 10:20 AM. After reviewing the resident's clinical record, Employee #28 acknowledged the aforementioned findings. The record was reviewed on April 27, 2009.

5. The physician failed to follow up a positive finding to the left breast for Resident F1.

A review of a radiology report dated December 3, 2007 revealed, " ...Diagnosis: Routine GYN Exam, Examination: Mammogram Bilat diag [bilateral diagnostic] ...Full Result: Clinical History: Left breast mass ... Impression: Clinical History: Left breast mass ...Examination of the left

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 386 | Continued From page 102<br>breast shows an area of density in the lower-inner quadrant. This area is suspicious and biopsy is recommended. A sonogram was performed on this patient and a sonographic report is to follow. The mass mammographically and somographically is suspicious and biopsy is recommended. "<br><br>A review of the Attending [physician ' s note] dated December 12, 2007 did not mention the positive findings to the left breast.<br><br>A review of Resident F1's Physical Examination form dated February 20, 2008 revealed, "...Chest/Breast: left breast mass ..."<br><br>A review of the physician's order written signed and dated July 25, 2008 revealed, "Please make an appointment with interventional radiology...at [name of hospital] for breast biopsy (left breast) ASAP."<br><br>A review of the attending notes dated September 24, 2008 at 1 PM revealed, "...f/u [follow up] left breast mass ...4. Left breast mass [unable to read] biopsy denied pain daughter notified ..."<br><br>A review of the clinical record lacked evidence that the physician had followed up on the left breast mass from February 20, 2008 to September 24, 2009.<br><br>A face-to-face interview was conducted on April 22, 2009 at 1:30 PM with Employee #26. He/she acknowledged that there was no follow up from February 20, 2008 to September 17, 2008. The record was reviewed on April 23, 2009. | F 386 | | |
| F 406 SS=D | 483.45(a) SPECIALIZED REHABILITATIVE SERVICES | F 406 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 406 | Continued From page 103<br><br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review, staff and resident's interview for one (1) of 12 supplemental residents, it was determined that the physical therapist failed to provide the requested services for Resident A4.<br><br>The findings include:<br><br>The physical therapist failed to provide appropriate and requested services to Resident A4.<br><br>Resident A4 was observed during an investigative tour of the facility seated in a wheel chair in his/her room on April 24, 2009 at approximately 11:45 AM. The resident's bilateral lower extremities were observed edematous.<br><br>The resident acknowledged that his/her feet were edematous and that the facility had failed to provide him/her with a wheelchair to enable him/her to maintain and or improve his/her toileting and transfer abilities. | F 406 | 1. Resident A4 was issued a standard wheelchair with elevating leg rest on October 21, 2008. Resident A4 was fitted for a customized wheelchair on April 17, 2009. Resident A4 was issued a footstool on April 24, 2009<br><br>2. Rehabilitation services will address the needs of all residents by screening quarterly according to the MDS schedule. All nursing consults to be entered on the rehab consult tracking form.<br><br>Rehab to address all consults within 2 business days. Rehab Program Coordinator/Designee to review consults during the daily Rehab meeting to ensure compliance.<br><br>3. the staff will be re-educated to use the Equipment Distribution Acknowledgement form will be placed in Residents chart after equipment from Rehab is issued.<br><br>4. The RPC/Designee will monitor the wheelchairs and supply needs monthly. This information is presented to the quarterly QA committee. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 406 | Continued From page 104<br>The resident stated: "I have not had a functioning wheel chair in this facility. I had to constantly remove the footrest from the wheelchair each time I need to use the bathroom. I took it off because I was always getting hurt each time I took it off to use the bathroom. Then sometime in February, I asked for something to elevate my feet while in my room. All I wanted was a little stool where I could keep my feet elevated. Each time I asked for the stool, I was told that the physical therapy department would be supplying me with a step stool. I used to have a low bed on the previous floor, and requested that I have that bed here to help with easy transfers in and out of bed. I still don't have that bed."<br><br>A review of the resident's clinical record: History and Physical, Physician's Progress Notes, and Nurses Notes revealed that the resident was admitted to the facility on September 19, 2008, and that the resident has bilateral lower extremity edema.<br><br>A further review of the resident's clinical record revealed that the resident was seen by the physical therapist from September 19 to December 29, 2008 and February 25 to March 26, 2009 as evidenced by dated and signed "Physical Therapy Progress Notes" in the resident's clinical record. A further review of the resident's clinical record revealed that the physical therapist followed-up on the physician's order for low bed and footstool on March 2, and 20, 2009 as evidenced by the "Physical Therapy Screen Form" with comments that referred the resident's request for low bed to nursing and housekeeping. The screening failed to address the request for footstool. | F 406 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ________ B. WING ________ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 406 | Continued From page 105<br>The physical therapist failed to provide appropriate and requested services to Resident A4.<br><br>A face-to-face interview was conducted on April 24, 2009 at approximately 2:45 PM. with Employee #3. He/she acknowledged that the resident took the footrest off the wheel chair because of the hindrance to independent toileting and personal hygiene. He/she said, "I have placed an order for a new wheelchair that will accommodate the resident's need."<br><br>On April 27, 2009 at approximately 2:00 PM, a footstool was observed by the resident's bedside. The resident was out of the facility for a medical appointment and therefore was unavailable for a follow-up interview. The record was reviewed on April 27, 2009. | F 406 | | |
| F 425<br>SS=D | 483.60(a),(b) PHARMACY SERVICES<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. | F 425 | 1. The multi-dose vials that were not initialed or dated were discarded. The thermometer in the refrigerator was replaced immediately. The emergency box and interim boxes were replaced.<br><br>2. A medication inspection of all units was conducted. This included review of the multi-dose vial, refrigerator temperatures and emergency and interim boxes.<br><br>3. An in-service was conducted with the clinical team on pharmaceutical services. This includes the dating and review of multi-dose vials. Review of the refrigerator temperatures and emergency and interim boxes. An in-service was conducted with the nursing clinical team on pharmaceutical serviced including procedures that assure the accurate receiving, dispensing 0and administering of all drugs and biologicals.<br><br>4. The pharmacist reviews the units on all aspects of pharmacy services. This information is presented to the quarterly QA team. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING<br>B. WING | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 425 | Continued From page 106 | F 425 | | |

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interview, it was determined that the facility staff failed to initial or date one (1) of two (2) multi-dose vials when first opened, properly monitor one (1) of eight (8) medication refrigerators for temperatures, replace two (2) of eight (8) emergency boxes and one (1) of one (1) interim box in a timely manner.

The findings include:

1. Facility staff failed to initial or date multi-dose vials when first opened.

A . On April 22, 2009, at approximately 2 PM, during the inspection of the medication refrigerator on one south, a multi-dose Lorazepam 2mg/ml, 10 ml vial was observed opened. The vial was not initialed or dated.

A face-to-face interview was conducted at the time of the observation. Employee #43 acknowledged that the vial was not initialed or dated when first opened.

B. On April 21, 2009, during the inspection of the medication carts, multi dose medication was observed the box of Foradil Aerolizer and Xopenex, both multi-dose medications, were observed opened, not dated or initialed.

The container of Foradil Aerolizer, stated " Date should not exceed four (4) months from date of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW WASHINGTON, DC 20001** |

| (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 425 | Continued From page 107<br>opening "<br><br>The container of Xopenex, stated " Once the foil pouch is opened, the vials should be used within two (2) weeks. "<br><br>A face-to-face interview was conducted at the time of the observation. Employee # 7 acknowledged that the containers were not initialed or dated when first opened.<br><br>2. Facility staff failed to properly monitor medication refrigerator temperatures.<br><br>On April 21, 2009, during the inspection of the medication storage areas, the thermometer in the medication refrigerator on 4 North was observed not registering the temperature. The dial on the thermometer was 42 degrees (°) Fahrenheit (F). The thermometer was removed from the refrigerator and placed on top of the counter from 12:10 PM until 12:30 PM. At 12:30 PM, the thermometer still read 42 ° F. Employee #21 replaced the thermometer and adjusted the refrigerator to the proper temperature.<br><br>A face-to-face interview was conducted at the time of the observation with Employee #21. He/she acknowledged that the thermometer was not working.<br><br>3. Facility staff failed to replace emergency boxes and the interim box in a timely manner.<br><br>On April 22, 2009 between 2:00 PM and 4:00 PM, during the inspection of the medication storage areas, the emergency box sign-out sheet for 2 South recorded that Nitroglycerin 0.4 mg sublingual tablets were removed on April 4, 2009 | F 425 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 425 | Continued From page 108<br>and the emergency box sign-out sheet for 3 North recorded that Kayexalate was removed on March 10, 2009. | F 425 | | |
| F 428<br>SS=D | 483.60(c) DRUG REGIMEN REVIEW<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that facility staff failed to consistently act upon the pharmacist ' s recommendations for two (2) residents and that the pharmacist failed to recommend discontinuing medication not used for six (6) months for one (1) resident. Residents #1 and 30.<br><br>The findings include:<br><br>1. Facility staff failed to act upon the Pharmacist's recommendations in a timely manner for Resident #1.<br><br>The consultant pharmacist recommendations dated January 28, 2009 revealed, " Recommendation: ... [Resident #1] is on Vitamin C and Zinc for wound healing. Please consider discontinuing the Vitamin C and Zinc and | F 428 | 1. The physician has reviewed resident #1 and made changes to the medication regime to meet the needs of the residents. Resident #30 is a closed record unable to retrospectively correct.<br><br>2. A review of the drug recommendation was conducted retrospectively during the last 30 days.<br><br>3. The Administrator met with the Medical Director regarding Drug regimes review. The Medical Director will review with the physicians.<br><br>4. A review of the medical records is conducted monthly. This includes pharmacy recommendation. This information is presented to the quarterly QA committee. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 428 | Continued From page 109<br>changing it to Stress with Zinc. Routed to: MD [medical doctor]"<br><br>At the time of this review, the record lacked evidence that the physician had act upon the recommendation from the consultant pharmacist made on January 28, 2009.<br><br>A face-to-face interview was conducted on April 23, 2009 at 3:50 PM with Employee #12. He/she acknowledged that the consultant pharmacist recommendations were not act upon. The record was reviewed April 23, 2009.<br><br>2. The pharmacist failed to recommend the discontinuation of Ambien for Resident #30, a closed record, who did not use the medication for six (6) months.<br><br>The resident was admitted to the facility on August 1, 2008, was hospitalized on April 7, 2009 and discharged from the facility on April 13, 2009.<br><br>According to the admission orders dated August 1, 2008 the resident was ordered Ambien 5 mg at bedtime for insomnia. The order was renewed September 30, October 28, November 25, 2008 and January 16, 2009. The resident was hospitalized February 15 through 26, 2009 and Ambien was not reordered when the resident returned to the facility.<br><br>A review of the MARs for August, September, October, November and December 2008 and January and February 2009 revealed that the resident never received Ambien.<br><br>The pharmacist reviewed the drug regimen on September 8, October 6, November 5, and | F 428 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 428 | Continued From page 110<br>December 3, 2008 and January 6, 2009. The pharmacist made no recommendation to discontinue Ambien.<br><br>A face-to-face interview was conducted with Employee #26 on April 24, 2009 at 5:00 PM. He/she acknowledged that the Ambien was not used for six (6) months and should have been discontinued. The record was reviewed April 24, 2009. | F 428 | | |
| F 431 SS=F | 483.60(b), (d), (e) PHARMACY SERVICES<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to | F 431 | 1. All treatments carts, tackle boxes and emergency carts were checked by the nursing management team. These boxes were thoroughly cleaned, and expired, undated and unlabeled drugs were discarded.<br><br>2. A review of each treatment cart, tackle box and emergency cart was done.<br><br>3. An in-service was conducted with the clinical team on assessing the items in cart. Which include the storage of all drugs and biological in locked compartments under proper temperature controls.<br><br>4. Monitoring of the treatment carts, tackle boxes and emergency carts is done weekly by Nursing Management. This information will be presented to the quarterly QA committee. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 431 | Continued From page 111 | F 431 | | |

abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observations and staff interview, it was determined that facility staff failed to: store drugs and biologics in locked compartments as evidence by two (2) of eight (8) unlocked treatment carts, remove expired, and/or undated opened and unlabeled drugs and biologics from four (4) of seven (7) treatment carts, four (4) of eight (8) tackle boxes and four (4) of eight (8) emergency carts.

The findings include:

1. The treatment cart on 2N was observed unlocked and unattended on April 22, 2009 at 8:45 AM. Items observed in the treatment cart are listed below.

The treatment cart on 4N was observed unlocked and unattended on April 22, 2009 at 1:50 PM in four (4) of seven (7) treatment carts observed. Items observed in the treatment cart and tackle box are listed below.

2. Expired, undated and/or unlabeled drugs and biologics were observed in treatment carts, emergency carts and tackle boxes (box used for easy transport of dressing change equipment) as follows:

1S Treatment Cart

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 431 | Continued From page 112<br>Sterile Water 1000cc no date when opened with approximately 300 cc left<br>Sterile Normal Saline 100 ml, two (2) bottles, undated when opened<br>Dermal Wound Cleanser 8 oz bottle, undated when opened<br>Solosite Gel Dressing expired November 2007<br>Coversite dressing, four (4) opened packages, with " Use only if unopened " on cover<br>Alginate dressing opened with " Do not use if opened " on front of dressing package<br>Hydrocolloid wound dressing expired June 2008<br>Betadine prep pad expired October 2008<br><br>1S Emergency Cart<br>KY Jelly, five (5) one ounce packages expired March 2009<br><br>1N Emergency Cart<br>Three (3) IV (intravenous) starter kits expired January, 2009<br>One (1) open suction kit<br><br>1N Tackle Box<br>Alginite dressing opened with " Do not use if opened " on front of package<br>One (1) tube of Triple Antibiotic Ointment unlabeled and undated when opened<br>One (1) tube of Antifungal Extra Thick cream 3.25 oz undated when opened and unlabeled<br>MPM Wound and Skin Cleanser undated when opened<br>One (1) pair of scissors with brown debris on the inner and outer cutting surfaces<br><br>The above findings for the 1st floor were acknowledged by Employee #8 on April 22, 2009 at 9:30 AM. | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 431 | Continued From page 113<br>2S Tackle Box:<br>One (1) bottle of MPM Wound Cleanser undated when opened<br>One (1) tube of Triple Antibiotic Ointment undated when opened<br><br>2N Treatment Cart<br>One (1) bottle of MPM Wound Cleanser undated when opened<br>Two (2) tubes Triple Antibiotic Ointment undated when opened<br>One (1) tube Antifungal Extra Thick Cream unlabeled and undated when opened<br>Extra Protective Cream unlabeled and undated when opened<br>One (1) package of No Sting Barrier expired March 2009<br>Three (3) IV starter kits expired January 2009<br>One (1) 8.5 cm endotracheal tube expired August 2007<br><br>The above findings for the 2nd floor were acknowledged by Employee #11 on April 22, 2009 at 8:45 AM.<br><br>3N Treatment Cart<br>Two (2) tubes Hydrocortisone Cream undated when opened and unlabeled<br>One (1) tube Miconazol Nitrate cream undated when opened and unlabeled<br>One (1) tube of Ben Gay undated when opened and unlabeled<br>Three (3) bottles Dermal Wound Cleanser undated when opened<br>One (1) bottle MPM Wound and Skin Cleanser undated when opened<br>One (1) tube Terbinafine Hydrochloride Cream unlabeled and undated when opened<br>One (1) tube Solosite Wound Gel unlabeled and | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 431 | Continued From page 114<br>undated when opened<br>One (1) tube Panifil undated when opened and unlabeled<br>One (1) bottle Nemphor Anti-itch lotion undated when opened and unlabeled<br>One (1) bottle Hydrocortisone Wound Cleaner undated when opened and unlabeled<br>Two (2) tubes Capsaicin Cream undated when opened and unlabeled<br>One (1) tube Safe Gel Hydrating Dermal Wound Dressing undated when opened and unlabeled<br><br>3S Emergency Cart<br>Five (5) packages of KY lubrication jelly expired July 1, 2008<br><br>3S Treatment Cart<br>Two (2) Xeroform Petroleum Dressing packages opened with " Sterile until pouch opened or damaged " on front of package<br>Two (2) Coversite 4 x 4 dressings opened and dated 4/18/09, 4/19/09<br>One (1) bottle Dermal Wound Cleanse undated when opened<br>One (1) bottle MPM Wound and Skin Cleanser undated when opened<br>One (1) tube Gentamycin Sulfate Cream unlabeled and undated when opened and stored in a plastic glove<br>One (1) tube Santyl Ointment undated when opened<br>One (1) tube Antifungal Cream unlabeled and undated when opened<br>One (1) tube Triple Antibiotic Ointment unlabeled and undated when opened<br><br>3N Tackle Box<br>Four (4) Foam 2 x 2 Dressings opened and not in | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 431 | Continued From page 115<br>package<br>One (1) 2 x 2 with 4 x 4 Overall Dressing opened and not stored in a package<br>One (1) tube of Silvadene 400 gm undated when opened<br>One (1) pair of scissors with brown debris on inner and outer surfaces<br>One (1) bottle Dermal Wound Cleanser undated when opened<br>One (1) Tweezers and one (1) nail scissors soiled with sticky substance and stored unpackaged<br>Two (2) Excel Ginate AG dressings opened with partial dressing in package with " Single sterile dressing for use only " on front of package<br>One (1) Coversite dressing opened with " Single use only " on front of package<br>Zerfoam dressing with partial dressing in package with " Single use only " on front of package<br>Three (3) tubes Solosite Wound Gel undated when opened<br>Three (3) tubes Santyl Ointment unlabeled and undated when opened<br>One (1) tube Silvadene unlabeled and undated when opened<br>One (1) tube Nystatin Cream unlabeled and undated when opened<br>One (1) Replicare Hydrocolloid Wound Dressing expired January 2009<br><br>3S Tackle Box<br>66 Hemocult cards expired January 2007<br>Two (2) scalpels unsheathed<br>One (1) Staple remover uncovered<br>One (1) tube Mineren cream 0.1% undated when opened and unlabeled<br>One (1) bottle Normal Sterile Saline 1000 ml opened and dated October 16, 2008 when opened<br>One (1) bottle Sterile Water dated September 5, | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 431 | Continued From page 116<br>2008 when opened<br>One (1) bottle of Sodium Chloride Irrigation Solution dated August 6, 2008 when opened<br><br>The above findings for the 3rd floor were acknowledged by Employees #12 and 19 on April 20, 2009 at 3:20 PM.<br><br>4N Treatment Cart<br>One (1) tube Solosite Ointment expired February 2008<br>Two (2) tubes Solosite Ointment undated when opened<br>One (1) tube Nystatin Cream undated when opened<br>Triamcinolone Cream undated when opened<br>One (1) bottle Ketoconzale shampoo expired January 24, 2008<br>One (1) tube Santyl Ointment undated when opened<br>One (1) bottle Dermal Wound Cleanser expired March 20, 2009<br>Four (4) tubes Antifungal Extra Thick Cream undated when opened<br>One (1) bottle MPD Wound Cleanser undated when opened<br>BD Vacutioner expired May 2008<br>UA collection tube expired 5/08<br><br>4S Treatment Cart<br>Three (3) tubes Santyl Ointment unlabeled and undated when opened<br>One (1) tube Ammonium Lactate Cream unlabeled and undated when opened<br>Three (3) tubes Solosite Wound Gel undated when opened<br>One (1) tube Kersol undated when opened and unlabeled<br>One (1) tube Nystatin Cream undated when | F 431 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____<br>B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 431 | Continued From page 117<br>opened and unlabeled<br>One (1) tube Gentamycin Ointment undated when opened and unlabeled<br>One (1) bottle Barrier Cream with Aloe unlabeled and undated when opened<br><br>The above findings for the 4th floor were acknowledged by Employees #13 and 28 on April 21, 2009 at 11: 25 AM. | F 431 | | |
| F 441<br>SS=D | 483.65(a) INFECTION CONTROL<br><br>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview for three (3) of 30 sampled residents and one (1) of 12 supplemental residents, it was determined that facility staff failed to maintain appropriate infection control practices during wound care treatment. Residents #1, 11, 16, and S1.<br><br>The findings include:<br><br>1. The wound care treatment for Resident #1's to the right lateral foot on April 22, 2009 at 10:10 AM and the following was observed :The aseptic | F 441 | 1. Resident #1's hospital acquired ulcer secondary to severe PVD is slowly healing. Resident #11's hospital acquired ulcer has resolved. The nursing staff has been reinstructed regarding wound technique and infection control for resident S1 chronic diabetic wound, and for resident #16.<br><br>2. All licensed nurses were observed for compliance with aseptic technique during all wound dressing changes.<br><br>3. An in-service will be provided to the licensed nurses for wound care and documentation and aseptic techniques.<br><br>4. Monitoring of dressing change and documentation is a part of the monthly QI program. This information is presented at the quarterly QA committee meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 441 | Continued From page 118<br>technique was followed while removing the old dressing and cleaning the wound. However, after applying the treatment cream Employee #12 was observed attempting to open the package of Coversite when it fell on the floor next to the bed in Resident #1's room. Employee #12 picked up the Covesite package opened the package and began shaking the dressing inside of the packet on to the clean field. After emptying the package, Employee #12 discarded the package into the red bag and proceed to wash his/her hands. Employee #12 applied the dressing to Resident #1, secured it with tape, removed his/her gloves and washed his/her hands.<br><br>Employee #12 failed to maintain a clean field when shaking the package of Coversite that had fallen on the floor.<br><br>2. Facility staff failed to sanitize a pair of scissors after they were used for a dressing change. Resident #11.<br><br>During a treatment observation conducted on April 27, 2009 at 10:00 AM of Resident #11's Stage III sacral wound, it was observed that the nurse failed to sanitize a pair of scissors after being used for a dressing change.<br><br>The nurse used scissors to cut open the new dressing package then placed it on a non-sterile field area. After the dressing change was completed, she took the scissors and placed it back in the clean treatment cart drawer without cleaning them.<br><br>A face-to-face interview was conducted on April 27, 2009 at 11:50 AM with Employee #5. He/she acknowledged that he/she placed the scissors in | F 441 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ___ B. WING ___ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 441 | Continued From page 119<br>the clean treatment cart drawer without cleaning them. The treatment was observed on April 27, 2009 at 11:25 AM.<br><br>3. Facility staff failed to maintain appropriate infection control practice during wound care treatment for Resident #16.<br><br>Employee #13 was observed during a wound care treatment to Resident #16's left malleolus on April 23, 2009 at approximately 11:25 AM. He/she rolled the unit's treatment cart to the resident's bedside. The treatment cart contained several wound treatment creams and other wound care supplies for the unit. He/she partially draped the cart, allowing open entry to the drawers which he/she frequented throughout the procedure. Employee #13 introduced self and the procedure she was about to administer to the resident. The Employee loosened the resident's left heel protector, left it in place under the resident's foot removed the old dressing, discarded it in the trash can, and applied wound cleanser to the resident's left malleolus without providing a barrier between the area being cleansed and the resident's heel protector and bed. Employee #13 cleansed the wound, applied cream on a 4x4 gauze, secured the wound with a tape and re-fastened the heel protector in place.<br><br>Employee #13 failed to maintain appropriate infection control practices when he/she: rolled the unit's treatment cart into Resident #16's room, failed to place a barrier between the resident's wound, the heel protector and the bed linen, failed to change the resident's soiled heel protector and bed linen, and placed the trash bag on the treatment cart. | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 441 | Continued From page 120 | F 441 | | |

Continued From page 120
A-face-to-face interview was conducted with Employees # 1 and 2 on April 27, 2009 at approximately 9:00 AM. They both acknowledged that it is against the facility policy to take the treatment cart to the resident's room. They also acknowledged that a barrier was necessary between the resident's treatment area and the heel protector and or bed.
Employee #13 was not available for interview. The record was reviewed April 27, 2009.

4. Facility staff failed to follow clean technique for a wound treatment for Resident S1.

A review of Resident S1's record revealed a physician's order dated February 12, 2009 at 3:00 PM that directed, "Cleanse right plantar foot wound with Dermal wound cleanser. Apply Silvercel, 4 x 4 wrap with Kerlix q d (daily)."

A wound treatment observation was conducted on April 24, 2009 at 11:05 AM with Employee #20. The resident was supine on the bed. There was no dressing covering the wound prior to the dressing change. Employee #20 stated, "The wound is closed. We're doing this (treatment) until [Resident S1] returns to the [wound clinic]. "

Employee #20 failed to place a barrier under the resident ' s right foot prior to cleaning the wound. The wound was cleaned in an up and down fashion with Dermal wound cleanser sprayed onto a 4 x 4 gauze pad. Employee #20 opened and removed the sterile Silvercel dressing with the same gloved hands used to cleanse the wound. He/she pulled the dressing from the sterile package, returned the dressing into the sterile package, changed gloves, opened a 4 x 4 gauze pad package and placed the Silvercel dressing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 441 | Continued From page 121<br>onto the 4 x 4 gauze pads and applied both to the plantar area of the right foot. Gloves were removed and Employee #20 wrapped Kerlix gauze around the resident's foot and secured with tape. Employee #20 then removed a pen from his/her pocket and wrote his/her initials, date and time on the tape on the resident.<br><br>The resident sat up on the bedside and walked to a chair a few feet away. There was no shoe or sock on the resident's foot to cover the dressing. | F 441 | | |
| F 454<br>SS=E | 483.70 PHYSICAL ENVIRONMENT<br><br>The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations during the environmental tour, it was determined that four (4) of 50 resident room fire doors were propped open, nine (9) of 58 screens were loose, damaged or missing, one (1) of four (4) telephones was not in working order, and five (5) of 74 air exchange vents were not securely attached to the wall or ceiling.<br><br>The environmental tour was conducted on April 20, 2009 from 12:30 PM through 4:30 PM and April 21, 2009 from 8:30 AM through 12:45 PM in the presence of Employees #21 and 22 who acknowledged the findings at the time of the observation.<br><br>The findings include:<br><br>1. The following fire doors were observed propped open in resident rooms 301, 302, 305, | F 454 | 1. The doorstops that were used to hold the doors open were removed and discarded. The window screens were adjusted repaired and/or replaced. An order was placed for a public pay phone and the exchange air vents were properly secured.<br><br>2. A review of doors (usage of door stops), window screens, telephones and air vents was conducted.<br><br>3. The Engineering/Maintenance and Environmental Services were re-educated regarding the physical environment. The Environmental Services and nursing staff were re-educated regarding doors not being propped open.<br><br>4. The Director of Engineering monitors the physical environment weekly with a log and provides findings to the QA committee quarterly. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 454 | Continued From page 122<br>and 421 in four (4) of 50 resident rooms observed.<br><br>2. The following screens were observed loose, damaged or missing in the following rooms: 2S dining room, 211, 214, 300, 312, 316, 320, 407 and 421 in nine (9) of 58 resident and dining rooms observed.<br><br>3. The public pay telephone on the 4th floor located in the elevator area between 4N and 4S was not in working order. There was no sign posted to indicate that the telephone was not working in one (1) of four (4) public pay telephones observed.<br><br>4. Exchange air vents were not securely attached to the wall/ceiling in the following areas: room 118, 1N soiled linen room, 1N shower room, 2N janitor closet and 2S shower room on five (5) of 74 rooms observed. | F 454 | | |
| F 468 SS=D | 483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS<br><br>The facility must equip corridors with firmly secured handrails on each side.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations during the environment tour, it was determined that handrails were not securely attached to the walls in two (2) of four (4) floors.<br><br>The environmental tour was conducted on April 20, 2009 from 12:30 PM through 4:30 PM and April 21, 2009 from 8:30 AM through 12:45 PM in the presence of Employees #21 and 22 who | F 468 | 1. The handrails identified during the survey was repaired immediately.<br><br>2. Maintenance Department staff checked all handrails in the building and found the hand rails to be securely attached to the walls in the hallways.<br><br>3. Maintenance Department staff was re-educated to conduct daily environmental records to detect, replace and secure handrails and cap as needed.<br><br>4. Monitoring of the environments which includes Handrails is done by the Engineering Director and/or supervisor monthly. This information is presented to the quarterly QA team committee. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 468 | Continued From page 123<br>acknowledged the findings at the time of the observation.<br><br>The findings include:<br><br>Hand rails were not securely attached to walls in the following areas: near the soiled utility room on 1N and in the hallway between 2N and 2S. Additionally, the hand rail by the 1N day room was missing an end cap on two (2) of four (4) floors observed with hand rails. Employees #21 and 22 secured the hand rails at the time of the observations. | F 468 | | |
| F 469 SS=D | 483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL<br><br>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations during survey period, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insect observations on three (3) of eight (8) nursing units.<br><br>The findings include:<br><br>Flying insects were observed in the following areas:<br>April 20, 2009 on 1N room 122 at 9:10 AM in the presence of Employees #21 and 22.<br>April 20, 2009 on 3S room 322 at 3:00 PM in the presence of Employees #21 and 22.<br>April 22, 2009 on 3S, day room at 11:25 AM in the | F 469 | 1. Rooms 112, 322, 3South day and shower room and room 110 were rechecked for evidence of the fruit flies that had been noted during the survey. While no fruit flies were evident. The cited areas were cleaned and in all cases food items were found in the nearby trashcans. The cans were disinfected and new bags were installed in them.<br><br>2. The facility was checked and all rooms were found to be free of insects.<br><br>3. The Environmental Director has contacted Western Pest Control Company to increase the frequency of their visits. Housekeeping and Nursing staff were advised to immediately remove any open or partially use food item from room and replace trash can liners (bags) when a food material are noted.<br><br>4. The Director of Environmental Services and Supervisor monitor the facility monthly for insects. This Information is reported to the quarterly QA committee. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______<br>B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **J B JOHNSON NURSING CENTER** | **901 FIRST STREET NW**<br>**WASHINGTON, DC 20001** |

| (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 469 | Continued From page 124<br>presence of Employee #21.<br>April 24, 2009 on 3S shower room at 11:20 AM in the presence of Employee #21.<br>April 26, 2009 on 1S day room at 7:30 AM in the presence of Employee #21.<br>April 27, 2009 on 1S room 110 at 9:20 AM in the presence of Employee #20.<br><br>Employees #20, 21 and 22 acknowledged the findings at the time of the observation. | F 469 | | |
| F 492<br>SS=E | 483.75(b) ADMINISTRATION<br><br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, staff interview and record review for one (1) of 30 sampled residents facility staff failed to include the name of the nurse who pronounced one (1) resident who expired in the facility on the death certificate, maintain a 3-day supply of non-perishable food, ensure washing temperatures for the laundry were between 140 degrees Fahrenheit (F) and 160 F and ensure that hot and cold food temperatures were within range at the point of delivery to the residents. Resident #28.<br><br>The findings include:<br><br>1. Facility staff failed to include the name of the nurse who pronounced Resident #28, who expired in the facility, on the death certificate. | F 492 | 1. A review of record for resident #28 was done unable to retrospectively correct. The hospice company was contacted to advise of finding. The emergency menu has been revised for the lunch on the second day to delete cold cut sandwiches and include a non perishable item. A new log was developed and provided to the laundry personnel to document the water temperatures. The food provided to the residents was re-heated as needed.<br><br>2. A review of residents pronounced by hospice was done no other resident was affected by this practice. The emergency menu was reviewed by the licensed Dietician. The Environmental Service Supervisor checked to ensure all logs are posted. Food temperatures were checked to ensure the temperatures are accurate.<br><br>3. The hospice was notified regarding death certificate requirement in accordance with the District of Columbia Act 9-299. The Dietician will review the 3 day menu. The Environmental Services Director will re-educate staff. The Food Services Director has re-educated dietary staff regarding dietary services and protocol. Counseling of staff will take place as indicated.<br><br>4. A review of the closed medical record is a part of the monthly QA program. Additionally the Dietary and Environmental Services Directors monitor the services in their department. This information is presented to the quarterly QA committee. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 492 | Continued From page 125<br><br>A review of Resident #28 ' s closed record revealed the following nurses ' notes:<br>November 28, 2008 at 2:05 AM: " Resident ' s vital signs were unobtainable. Unable to get respiration, unable to get pulse and unable to get blood pressure. The hospice nurse was notified by charge nurse. Awaiting hospice nurse's arrival. "<br><br>November 28, 2008 at 6:00 AM: " Resident was found unresponsive at 2:00 AM during night rounds. No pulse rate, no blood pressure, no respiratory rate noted. Hospice nurse was notified and came at 5AM to pronounce the body ... "<br><br>A review of Resident #28 ' s death certificate revealed that line 41, " Name of person Pronouncing Death (if other than certifier) " was blank. In line 45a, " Certifier " was the signature of the physician.<br><br>According to D.C Act 9-299 dated October 23, 1992, " (j) In the case of an expected death at a decedent ' s place of residence at the time of death, attended by a treating physician or a registered nurse working in general collaboration with the treating physician, the attending registered nurse may sign the pronouncement of death section of the death certificate promptly following death. " The record was reviewed April 22, 2009.<br><br>2. Facility staff failed to maintain three (3) day supply of non-perishable food for emergency use. This observation was made in the presence of Employee #24 on April 20, 2009 at 12:30 PM who acknowledged the findings at the time of the | F 492 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 492 | Continued From page 126<br>observations.<br><br>An observation of the emergency food storage area was conducted on April 20, 2009 at 12:30 PM. One (1) case of Rice Crispies expired April 6, 2009. One (1) case of Raisin Bran expired April 10, 2009. 50 packets of Swiss Miss hot chocolate expired April 6, 2009. According to the emergency menu, cold cuts were scheduled for lunch on the second day of the three (3) day emergency menu. These observations were made in the presence of Employee #24 who acknowledged the findings at the time of the observations.<br><br>3. Facility staff failed to monitor the hot water temperatures during the wash cycle to disinfect soiled linens.<br><br>According to 22DCMR 3254.20, " To effectively disinfect soiled linens, hot water temperature shall be one hundred and fifty degrees to (150 [degrees]) to one hundred sixty degrees Fahrenheit (160 [degrees] F) during the wash cycle.<br><br>During the inspection of the laundry area on April 22, 2009 at 11:30 AM, it was determined that facility staff failed to maintain a laundry wash temperature log.<br><br>During the time of the inspection, wash temperature logs could not be located. A face-to-face interview with Employee #29 at the time of the inspection, stated, " We ran out of log sheets about a week and a half ago. I watch the wash temperatures. The wash should be about 160 (degrees Fahrenheit [F]) and the rinse about 140 F. I don ' t know where the log sheets are. " | F 492 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 492 | Continued From page 127<br>The wash temperature wash sheets could not be located at the time of the observation.<br><br>4. Facility staff failed to ensure that hot and cold food temperatures were within range at the point of delivery to the resident.<br><br>According to 22 DCMR 3220.2, " The temperature for cold foods shall not exceed forty five degrees 45[degrees] Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140 [degrees]) Fahrenheit at the point of delivery to the resident. "<br><br>A test tray was conducted on April 21, 2009 at the lunch meal in the presence of Employee #24. The food was plated at 1:22 PM and left the kitchen at 1:27 PM. It arrived on the unit at 1:30 and four (4) CNAs (certified nurse aide) began passing the trays immediately. The temperature of the foods on the test tray was tested at 1:45 PM as follows:<br>Baked chicken leg and thigh 130 F<br>Noodles 134 F<br>Pureed beets 128 F<br>Pureed noodles 124 F<br><br>Employee #24 acknowledged the findings at the time of the observations. | F 492 | | |
| F 504 SS=D | 483.75(j)(2)(i) LABORATORY SERVICES<br><br>The facility must provide or obtain laboratory services only when ordered by the attending physician.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review, staff interview for one | F 504 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 504 | Continued From page 128<br>(1) of 30 sampled resident, it was determined that facility staff failed to obtain a physician's order for a Dilantin level blood draw for Resident #12.<br><br>The findings include:<br><br>A review of the resident clinical record revealed that a Dilantin level blood draw was done on April 1, 2009. The Dilantin level was less than 2.5 @ mg/L.<br><br>A review of the resident's clinical record revealed a telephone order dated February 18, 2009 at 2:00 PM and signed by the physician on February 27, 2009, that directed: "D/C (Discontinue) Phenytoin...cap 100mg P.O. T.I.D. for seizure. Resident refuses to take it. Says ...does not need it."<br><br>A further review of the resident's clinical record including the "Physician's order" sheets signed and dated by the physician on February 27 and April 3, 2009 lacked evidence of an order for the Dilantin level blood draw that was done on April 1, 2009.<br><br>A face-to-face interview was conducted with Employee #28 on April 22, 2009 at approximately 12:00. After reviewing the resident's record, Employee #28 acknowledged that the resident's clinical record lacked evidence of an order to draw the resident's Dilantin level on April 1, 2009. Employee #28 stated "The order for a Dilantin level blood draw automatically discontinued when the physician discontinued the Dilantin on February 18, 2009." He/she acknowledged that there was no order for the Dilantin level blood draw on April 1, 2009. The record was reviewed April 22, 2009. | F 504 | 1. The medical record for resident #12 was reviewed. The resident was without seizures. The licensed nurse was advised about ensuring that orders are in place for lab. Unable to retrospectively correct.<br><br>2. All other residents receiving dilantin were reviewed for compliance with doctors order for routine dilantin lab studies.<br><br>3. Staff has been re-educated on ensuring compliance with MD's orders.<br><br>4. A review of the physicians orders including lab is a part of the comprehensive audit of medical record conducted monthly. This information is presented to the quarterly QA monthly. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW<br>WASHINGTON, DC 20001 |

| (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 505<br>SS=D | 483.75(j)(2)(ii) LABORATORY SERVICES<br><br>The facility must promptly notify the attending physician of the findings.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to promptly notify the physician that the laboratory report for the ordered monthly therapeutic drug monitoring for Phenytoin (Dilantin) was unavailable for Resident #16.<br><br>The findings include:<br><br>Facility staff failed to promptly notify the physician that the ordered monthly therapeutic drug monitoring for Phenytoin (Dilantin) was unavailable related to the resident's combativeness during blood draw.<br><br>According to an annual Minimum Data Set (MDS) assessments completed on September 27, 2008, the resident's diagnosis included seizure disorder.<br><br>A review of Resident # 16's clinical record revealed "Physicians' Order" sheets signed and dated June 26, September 26, and November 21, 2008, January 23, and April 3, 2009 that directed "Dilantin level every month" first initiated on February 9, 2007.<br><br>Further review of the resident's clinical record revealed that the resident was consistently administered Dilantin 100 mg twice daily by mouth as per the physician's orders in the aforementioned "Physician's Order" sheets as | F 505 | 1. The medical record for resident #16 was reviewed. The lab was contacted and labs that were done were placed on record. Unable to retrospectively notify MD regarding resident's refusal of some of the lab studies.<br><br>2. A review of lab request for the last quarter was completed.<br><br>3. Re-education of all licensed staff regarding physicians notification or refusal of care. Utilizing the physician book for refusals which is reviewed by the physicians during weekly rounds.<br><br>4. Monthly medical records audits are conducted. This information is presented at the quarterly QA committee meeting. | 6/25/09 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 505 | Continued From page 130<br>evidenced by the initials in the boxes across the entry for Dilantin 100mg in the resident's "Medication Administration Record" (MAR) during the periods covered by the aforementioned "Physician's Order" sheets; that is June 2008 through April 2009.<br><br>The resident's clinical record lacked evidence of laboratory reports for monthly therapeutic monitoring for Dilantin.<br><br>A face-to-face interview was conducted with Employee # 28 on April 27, 2009, at approximately 10:10 AM. After reviewing the resident's clinical record, Employee # 28 acknowledged that the laboratory reports for monthly therapeutic monitoring for Dilantin was unavailable. He / she said, "The resident was sometimes combative and therefore the blood for Dilantin level was not drawn. He / she acknowledged that the resident's clinical record lacked evidence that the physician was promptly notified that the ordered Dilantin level was not performed. The record was reviewed April 27, 2009. | F 505 | | |
| F 514 SS=E | 483.75(l)(1) CLINICAL RECORDS<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. | F 514 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 131<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review staff and resident's interview for 11 of 30 sampled residents, it was determined that facility staff failed to maintain clinical records in accordance with accepted professional standards and practices as evidenced by: inaccurate weight record and behaviors for one (1) resident, failed to correctly transcribe an order for Seroquel for one (1) resident, complete the admission behavior form for one (1) resident, maintain Dilantin levels on the resident's record, identified one (1) resident as certified for skilled rehabilitation services, ensure that that clinical records were in order for four (4) residents, document the administration of a Scopolamine patch and Haldol and humidifier bottle changed for one (1) resident, accurately document the administration of Duragesic for one (1) resident, and identify target behaviors for a behavior flow sheet for one (1) resident. Residents #1, 2, 5, 10, 12, 13, 23, 28, 29, and 30.<br><br>The findings include:<br><br>1. Facility staff failed to record the correct weight and document the resident behaviors on the Behavior flow sheet for Resident #1.<br><br>A. Facility staff failed to record Resident #1's correct weight in the clinical record.<br><br>The "Monthly Weight and Vital Signs Record" Year 2008 revealed, " ... September 9/2/08 Weight 123 [pounds], Reweight 9/18/08-155 [pounds]; October 10/16/08 Weight 113 [pounds] | F 514 | 1. A review of the cited residents' medical records was done. Unable to retrospectively correct documentation concems for resident 1, 2, 5, 10, 12, 13, 23, and 29. Residents #28 and #30 are closed records. Records for residents #1, 5, 10 and 23 have been placed in systematic and chronological order.<br><br>2. A review of the medical records has been conducted and records are being reorganized as indicated.<br><br>3. The nursing staff will be re-educated on order transcription; physician orders, behavior documentation and maintaining charts in a chronological, systematic and organized manner. The vacant position in medical records has been filled.<br><br>4. A review of the medical records is a part of the comprehensive medical records audit. The information is presented at the Quality Assurance Committee meeting. | 6/25/09 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 132<br>... "<br><br>A review of the MDS discharge tracking form dated October 8, 2008 revealed that the resident was discharged to an acute care facility.<br><br>According to the clinical record the resident was readmitted to the facility on October 16, 2008 and his/her readmission weight was 113 pounds.<br><br>The clinical record reflects that Resident #1 lost 42 pounds between September 25, 2008 and October 16, 2008 [21 days].<br><br>A face-to-face interview was conducted on April 23, 2009 at 2:30 PM with Employee #12. He/she stated, "The Reweight on September 18, 2008 = 155 pounds was documented incorrectly. We [the facility] had been monitoring the resident's weight." The record was reviewed on April 23, 2009.<br><br>B. Facility staff failed to document the resident behaviors on the Behavior flow sheet for Resident #1 who receives Remeron.<br><br>The Report of Consultation dated December 16, 2008 revealed, " ...Recommendations: continue current course of treatment ...Remeron 45 mg daily for Depression " .<br><br>According to the significant change Minimum Data Set completed November 21, 2008 and March 23, 2009 revealed that Depression was coded in Section I [Disease Diagnoses].<br><br>The March 2009 physician's orders dated and signed by the physician April 4, 2009 "...Mirtazepine tab 45mg for: Remeron take 1 | F 514 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING _____ B. WING _____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 133 | F 514 | | |

tablet via peg-tube daily for appetite ...
Psych consult as needed ... "

A review of the clinical record lacked evidence that behavioral monitoring sheets were implemented to document the resident ' s behavior while receiving Remeron.

A face-to-face interview was conducted on April 23, 2009 at 2:30 PM with Employee #17. He/she acknowledged that the behavioral flow sheets were not implemented. The record was reviewed on April 23, 2009.

2. The facility staff failed to correctly transcribe an order for Seroquel for Resident #2.

A review of the clinical record for Resident #2 revealed the following telephone orders. The first order was dated February 14, 2009 at 4:45 PM and stated "Start Seroquel 25 mg. PO [by mouth] BID [twice a day] PRN [as needed] for agitation. Another telephone order dated February 14, 2009 at 8:30 PM documented the following orders, D/C [discontinue] Seroquel 25 mg. PO BID PRN for agitation. "Two other orders were documented at the same time as the previous orders; "Start Seroquel 25 mg. PO at 9 AM for agitation, "and "Start Seroquel 50 mg. PO Q HS [every night] for agitation. "

A review of the Medication Administration Records (MAR) revealed the following transcription dated February 15, 2009 on the April, 2009 PRN MAR. "Seroquel Tab 25 mg (Quetiapine) Take 1 [one] tablet by mouth every morning for agitation. " There was no documented evidence on the MAR that this PRN dosage was ever administered.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 134<br><br>A face-to-face interview was conducted with Employee #28 at approximately 2:10 PM on April 21, 2009. He/she acknowledged that the PRN order, "Seroquel Tab 25 mg (Quetiapine) Take 1 [one] tablet by mouth every morning for agitation. "was incorrectly transcribed to the MAR. The record was reviewed on April 20, 2009.<br><br>3. Facility staff failed to complete the admission "Target Behavioral Symptoms" form for Resident #5.<br><br>The "Target Behavioral Symptoms "forms dated March and April 2009 lacked documentation indicating that the forms were consistently completed.<br><br>A face-to-face interview was conducted on April 21, 2009 at 10:30 AM with Employee #28. He/she acknowledged that the evaluations were not completed. The record was reviewed on April 21, 2009.<br><br>4. Facility staff failed to ensure that the January and February 2009 Dilantin levels were in the record for Resident #12.<br><br>According to the admission Minimum Data Set (MDS) completed on December 16, 2008 the Resident #12 was admitted to the facility on December 3, 2008 with the admission diagnoses that included seizure disorder and anemia.<br><br>A review of the resident's clinical record revealed the following:<br><br>A "Physician Order Sheet and Plan of Care" dated December 3, 2008, signed and dated by | F 514 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 135 | F 514 | | |

the physician on December 12, 2008 that directed "Dilantin 100 mg 1 Cap PO TID (Capsule by mouth three times daily) for seizure."

An "Interim Order Form" with a telephone order dated December 4, 2008 at 9:15 AM, signed and dated by the physician on December 12, 2008 that directed "Dilantin level every month for seizure."

The resident's clinical record lacked evidence that the results of the Dilantin level for January and February 2009 were in the record.

A face-to-face interview was conducted with Employee #28 on April 22, 2009 at approximately 2:30 PM. After reviewing the resident's clinical record, Employee #28 acknowledged that the Phenytoin (Dilantin) level for January and February 2009 were not in the record. The record was reviewed April 22, 2009.

5. Facility staff inaccurately identified Resident #13 as receiving skilled services.

A review of Resident #13's record revealed pre-printed physician orders signed by the physician on May 7, July 9, November 10, 2008 and January 2 and March 9, 2009 that directed, "Certified as skilled LOC (level of care)."

According to the resident 's record, the resident was admitted on May 25, 2007 for skilled physical and occupational therapy services.

A face-to-face interview was conducted with Employee #31 on April 23, 2009 at 1:30 PM. He/she stated, "[Resident #13] no longer receives skilled services and hasn't for awhile

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 136 | F 514 | | |

now. [He/she] was seen by the Physical Therapist from December 7 through December 12, 2007. The occupational therapist saw [Resident #13] from May 29 through September 4, 2007. The speech therapist saw the resident from June 6 through October 23, 2007. The last skilled services that the resident received were December 12, 2007." The record was reviewed April 23, 2009.

6. Facility staff failed to maintain the Resident #23's record in order.

A review of Resident #23's record revealed that laboratory test results were filed in the following order:
February 11, 2009 Complete Blood Count (CBC)
November 21, 2008 "Wheelchair Repair Evaluation Results" form
January 12, 2009 Electrocardiogram (EKG)
November 17, 2008 CBC
January 26, 2009 EKG Report
January 12, 2009 Basic Metabolic Panel (BMP)
February 3, 2009 Digoxin level
January 26, 2009 CBC
October 29, 2008 CBC
January 12, 2009 BMP
November 10, 2008 CBC
November 12, 2008 Sonogram of the kidney

A face-to-face interview was conducted with Employee #12 on April 24, 2009 at 7:15 AM. He/she stated, "We don't have unit clerks anymore, so the nurses do the filing. No one has tried to put the labs in order. " The record was reviewed April 23, 2009.

7. Facility staff failed to accurately transcribe medication orders, document that a scopolamine

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 137<br>patch was administered and that the oxygen humidifier bottle was changed weekly for Resident #28. This was a closed record.<br><br>A review of Resident #28's record revealed physician's orders dated September 23, 2008 that directed, " Scopolamine 1.5mg patch q 72 hours for secretions. "<br><br>A. The order was transcribed onto the September 2008 Medication Administration Record (MAR) as, "Scopalmintis 1.5mg po q 72 hours for secretions." There was no evidence that this medication was administered. There was no evidence that a Scopolamine patch was administered on September 23, 26 and 29, 2008 as ordered by the physician.<br><br>The order was transcribed onto the October 2009 MAR as, "Scopolamine 1.5 mg patch 1 72 hr for secretions." The patch was administered to the resident every 3rd day as evidenced by the nurses ' initials present for October 3, 6, 9, 12, 15, 18, 21, 24, 27 and 30, 2008. There were no discrepancies observed on the November 2008 MAR for the Scopolamine patch.<br><br>B. According to the admission orders dated September 23, 2008 and signed by the physician on October 10, 2008, "Haldol 1 mg 1 tab po q 8 hours for agitation. "<br><br>The order was transcribed onto the September 2009 MAR as "Haldol 1 mg 1 tab po q 8 hrs for agitation. "The time of administration were documented as, "11-7, 7-3, and 3-11." No specific time was indicated to administer the medication. Nurses' initials appear in the designated box on the September 2009 MAR | F 514 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 138<br>documenting that the resident received the medication three times each day for September 24, 25, 26, 27, 28, 29 and 30 2008. There was no documentation regarding the time the medication was administered either on the back of the MAR or in the nurse's notes.<br><br>A review of the October 2009 MAR revealed that facility staff designated that the Haldol be administered at 6:00 AM, 2:00 PM and 10:00 PM.<br><br>C. According to the admission orders dated September 23, 2008 and signed by the physician on October 10, 2008, "O2 at 2L/min via N/C ( oxygen at 2 liters per nasal cannula) for SOB (shortness of breath). Change humidifier every week on WEDS 3-11 & PRN (as needed)."<br><br>According to the October 2008 MAR, the area designated to document that the humidifier bottle was changed for October 22 and 29, 2008 were blank. There was no evidence in the nurses' notes that the humidifier bottle was changed.<br><br>There was no evidence in the record that the resident experienced any untoward effects as a result of the above cited issues.<br><br>A face-to-face interview was conducted on April 23, 2009 at 5:30 PM with Employee #2, who acknowledged the above cited issues.<br><br>8. Facility staff failed to document that a Duragesic patch was administered to Resident #29. This was a closed record review.<br><br>A physician ' s order dated August 8, 2008 directed, " Duragesic patch 50 mcg/hr apply 1 patch applied topically every 72 hours for chronic | F 514 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ______ B. WING ______ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 139 | F 514 | | |

pain. "

According to the February 2009 MAR, facility staff failed to document that the Duragesic patch was administered as evidence by lack of the nurse ' s initials in the designated area for February 12, 2009. According to the March 2009 MAR, facility staff failed to document that the Duragesic patch was administered as evidence by lack of the nurse ' s initials in the designated area for March 20, 23, 26, and 29, 2009.

A review of the nurses ' notes for February and March 2009 revealed that the resident had no complaints of pain during the above cited dates. There was no evidence in the nurses ' notes that the Duragesic patch had been applied on the above cited dates.

A face-to-face interview was conducted with Employee #1 on April 24, 2009 at 5:50 PM. He/she acknowledged the lack of the nurses ' initials for the administration of the Duragesic patch. The record was reviewed April 24, 2009.

9. Facility staff failed to identify target behavior symptoms for the " Psychoactive Medication Monthly Flow Record " for Resident #30.

A review of Resident #30 ' s record revealed that the resident was admitted to the facility on August 1, 2008.

"Psychoactive Medication Monthly Flow Record " for December 2008 and January, February, March and April 2009 were reviewed. The four (4) monthly flow records were completely filled out by facility staff and included three (3) sections each including episodes, interventions outcome

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095036 | A. BUILDING ____ B. WING ____ | 04/28/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| J B JOHNSON NURSING CENTER | 901 FIRST STREET NW WASHINGTON, DC 20001 |

| (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 514 | Continued From page 140 | F 514 | | |

and initials of nurse documenting.

No target behaviors are identified on the December 2008, January, February and April 2009 monthly flow records. The March 2009 monthly flow record identified "Delusions" in one (1) of the three (3) completed sections. The other two (2) sections lacked target behaviors, but were completely filled out.

A face-to-face interview was conducted with Employee #26 on April 24, 2009 at 6:00 PM. He/she acknowledged that the behavior flow sheets lacked target behaviors. The record was reviewed April 24, 2009.

10. Facility staff failed to maintain Residents #1, 5 and 10 clinical record in a readily accessible and systematically organized manner.

During record review of Residents #1, 5 and 10 the laboratory reports and a psychiatry consult was not available and/or filed in section of the record designated for another discipline.

A face-to-face interview was conducted with Employee #12 on April 24, 2009 at 7:15 AM. He/she stated, "We don't have unit clerks anymore, so the nurses do the filing. No one has tried to put the labs in order. " The records were reviewed April 24, 2009.