

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/07/2007</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY LIVINGCENTER-NW</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3333 WISCONSIN AVE NW WASHINGTON, DC 20018</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments  A licensure monitoring survey was conducted on May 7, 2007. The following deficiencies were cited based on record review and staff interview. The sample included 22 records.	L 000		
L 051	3210.4 Nursing Facilities  A charge nurse shall be responsible for the following:  (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;  (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;  (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;  (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;  (e) Supervising and evaluating each nursing employee on the unit; and  (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents.  This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 22 sampled residents, it was determined that the charge nurse failed to assess Resident #4's emotional status and notify the attending physician after the resident made a statement of suicidal ideation.	L 051	L051 1. The Social Worker assigned to the floor met with the resident on May 7, 2007 and did not find any mood or behavioral changes. The Psychiatrist followed up with the resident on May 7, 2007 and found no signs of suicidal ideation. Resident Number 4 has been discharged.  2. The Social Services Department will follow up with an audit on the residents that the Social Work Intern has written progress notes. Any behavioral issues identified will be reported to the Charge Nurse and Nursing Supervisor for immediate intervention and monitoring.  3. The Social Services Department does not have any Social Work Interns at this time and does not plan on participating in that program. The Social Services Department has also contracted with a consultant who has been addressing any psychiatric issues that have been expressed by residents. In-service of Behavioral Monitoring, Suicidal Precautions will be reviewed with Nursing and Social Service staff.  4. The audit will be addressed at the QA meetings.  5. The plan shall be completed by June 21, 2007	<i>Review completed 5/15/07</i>

Health Regulation Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
STATE FORM 941311

TITLE: *Executive Director* (X6) DATE: *5/21/07*  
If continuation sheet 1 of 1

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*James M. Jones*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*Executive Director*

(X6) DATE  
*5/22/07*

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L 051	<p>Continued From page 1</p> <p>The findings include:</p> <p>Resident #4's most recent quarterly MDS (Minimum Data Set) dated February 15, 2007 included the following: Section B4 (Cognitive Skills for Daily Decision Making) moderately impaired; Section B5 (Indicators of Delirium-Periodic Disordered Thinking/Awareness) periods of altered perception or awareness of surroundings and mental function varies over the course of the day. The admission MDS dated September 14, 2006 included the diagnosis of Alzheimer's disease.</p> <p>A social services progress note dated March 6, 2007 revealed, "Intern was in the dayroom on the 7th floor and resident informed Intern that he/she felt like jumping out of the window. According to resident's chart resident has been diagnosed with Alzheimers. Intern informed [charge nurse's name], the nurse that works with him/her. He/She told me that he/she would talk to the resident. Social services will follow up with this resident ..."</p> <p>A review of the nurses' notes failed to reveal an assessment of the resident or notification of the attending physician after the aforementioned statement of suicidal intentions was made.</p> <p>A face-to-face interview was conducted with Resident #4 on May 7, 2007 at 9:20 AM. The resident was seated in the dayroom. He/She was oriented to person only. He/She was asked if [resident] remembered telling someone about wanting to jump from a window. The resident stated, "No, I don't remember, but I'm leaving tomorrow." The resident was scheduled for transfer to another facility on May 8, 2007.</p>	L 051		

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L 051	Continued From page 2  A face-to-face interview was conducted with the Resident Care Coordinator on May 7, 2007 at 10:00 AM. After reviewing the chart, he/she stated, "It doesn't look like anything was done. He/She [charge nurse] is off today." The record was reviewed on May 7, 2007.	L 051		
L 179	3229.1 Nursing Facilities  The facility shall provide social services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 22 sampled residents, it was determined that the social worker failed to follow up on Resident #4's statement of suicidal ideation.  The findings include:  Resident #4 's most recent quarterly MDS (Minimum Data Set) dated February 15, 2007 included the following: Section B4 (Cognitive Skills for Daily Decision Making) moderately impaired; Section B5 (Indicators of Delirium-Periodic Disordered Thinking/Awareness) periods of altered perception or awareness of surroundings and mental function varies over the course of the day. The admission MDS dated September 14, 2006 included the diagnosis of Alzheimer 's disease.  A social services progress note dated March 6, 2007 revealed, " Intern was in the dayroom on the 7th floor and resident informed Intern that he/she felt like jumping out of the window. According to resident 's chart resident has been	L 179	L179 1. The Social Worker assigned to the floor met with the resident on May 7, 2007 and did not find any mood or behavioral changes. The Psychiatrist followed up with the resident on May 7, 2007 and found no signs of suicidal ideation. Resident Number 4 has been discharged.  2. The Social Services Department will follow up with an audit on the residents that the Social Work Intern has written progress notes. Any behavioral issues identified will be reported to the Nurse Manager and ADNS, DNS for follow-up.  3. The Social Services Department does not have any Social Work Interns at this time and does not plan on participating in that program. The Social Services Department has also contracted with a consultant who has been addressing any psychiatric issues that have been expressed by residents.  4. The audit will be addressed at the QA meetings.  5. The plan shall be completed by June 21, 2007	

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L 179	Continued From page 3  diagnosed with Alzheimers. Intern informed [charge nurse 's name], the nurse that works with him/her. He/She told me that he/she would talk to the resident. Social services will follow up with this resident ... " There were no subsequent social service progress notes in the chart to show evidence of a follow up evaluation.  A face-to-face interview was conducted with the Resident Care Coordinator on May 7, 2007 at 10:00 AM. After reviewing the chart, he/she stated, " It doesn ' t look like anything was done."  The record was reviewed on May 7, 2007.	L 179		
L 183	3229.5 Nursisng Facilities  The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record, reviewed quarterly, and revised as necessary. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 22 sampled residents, it was determined that the social worker failed to write quarterly progress notes. Residents #1, 2 and 3.  The findings include:  1. A review of Resident #1 ' s record revealed the last social worker ' s progress note was written on January 14, 2007. The next quarterly social service progress note was due April 2007.  2. A review of Resident #2 ' s record revealed the last social worker ' s progress note was written on January 13, 2007. The next quarterly social service progress note was due April 2007.	L 183	L 183  1. Resident Number 1, Social Services completed a progress note for April on May 9, 2007.  Resident Number 2, Social Services completed a progress note for April on May 14, 2007.  Resident Number 3, Social Worker returned from medical leave and was able to locate missing quarterly which was dated April 19, 2007 for her discharge.  2. The Social Services Department will conduct audits of client medical records in order to monitor that Quarterly notes and necessary documentation and follow up is completed.  3. A monthly audit will be conducted to ensure that quarterly social services documentation is present for each resident. Corrections will be made as necessary.  4. The audit results will be put into the QA and addressed at the QA meetings.  5. The plan shall be completed by June 21, 2007.	

PRINTED: 05/11/2007  
FORM APPROVED

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L 183	Continued From page 4  3. A review of Resident #3 's record revealed the last social worker 's progress note was written on January 2, 2007. The next quarterly social service progress note was due April 2007.  A face-to-face interview was conducted with the Director of Nursing on May 7, 2007 at 12:10 PM. He/She stated that one (1) of the social workers resigned in March [2007]. He/She acknowledged the lack of quarterly progress notes by the social worker and attempted to locate documentation from the social service department. The records were reviewed on May 7, 2007.	L 183			