

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2006
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NAME OF PROVIDER OR SUPPLIER J B JOHNSON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW WASHINGTON, DC 20001
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L 000	Initial Comments An annual licensure survey, complaint investigation (C-06-072, DC00000966) and complaint/incident investigation (06-067/06-I-1203, DC00000957/DC00000963) was conducted on July 11 through 13, 2006. The following deficiencies were based on observations, record review and interviews with the facility staff and residents. The sample included 29 sampled residents based on a census of 193 residents on the first day of survey and four (4) supplemental residents.	L 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 on the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/ or executed solely because it is required by Federal and State Law.	
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.	L 051	L 051 3210.4 Nursing Facilities 1. The care plan for resident #W1 was updated to reflect contracture management. The Psychiatrist clarified the strength for Haldol Deconuate for Resident #20. The facility is unable to retrospectively correct the administration of potassium for resident J1, however a potassium (K+) level is scheduled to be drawn. 2. Care plans of all residents with splints were reviewed. There were no other residents found to be affected by this practice. 2. The charts of all residents on Haldol Deconuate was reviewed for strength of medication and clarified as needed. The residents on potassium liquid are monitored for full consumption of medication. There were no other residents found to be affected by this practice. 3. The Interdisciplinary Team (IDT) team was re-educated on updating care plans. The nursing personnel was re-educated on clarification of physician orders and medication pass of liquid medications. 4. The care plan and MAR audit update is a part of the Quality Improvement program and presented at the Quality Assurance meeting.	08/28/06

Health Regulation Administration

Annette Price
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator TITLE

8/4/06 (X6) DATE

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L 051	<p>Continued From page 1</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review for one (1) of 29 sampled residents and one (1) of four (4) supplemental residents, it was determined that the charge nurse failed to update one (1) resident's care plan for contracture management and clarify the strength for Haldol Decanoate for one (1) resident. Residents #20 and W1.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility staff failed to clarify the strength for Haldol Decanoate for Resident #20. <p>A review of Resident #20's record revealed a physician's order dated April 12, 2006, "Haldol Dec IM (intramuscular) every 2 weeks." There was no strength indicated.</p> <p>According to the manufacturer, Haldol Decanoate comes in 50 mg and 100 mg strengths.</p> <p>The facility's policy, "New Schedule III-V controlled Substance Medication and non Controlled Substance Medication Orders," #4.3, effective August 1, 2002, page 1, under "Process: 1.1.1 New Order must include ... 1.1.3 Drug name, strength, dosage ..."</p> <p>A face-to-face interview was conducted with the charge nurse on July 11, 2006 at 1:10 PM. He/ she stated, "We called the pharmacy and they told us that the Haldol only comes in one strength. We didn't call the doctor, we believed the pharmacy." The record was reviewed July 12, 2006.</p> <ol style="list-style-type: none"> 2. Facility failed to Resident W1's contracture management care plan. 	L 051		

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L 051	Continued From page 2 A review of Resident W1's record revealed a "Contracture Management Interdisciplinary Care Plan" which was initiated on July 15, 2005 by the physical therapist. The identified problem was an upper extremity contracture. The resident was observed on July 13, 2006 at 7:56 AM with a splint on the left hand. The care plan had not been reviewed or updated since it was developed. The record was reviewed on July 13, 2006.	L 051		
L 055	3211.4 Nursing Facilities Weekly time schedules shall be maintained and indicate the number and classifications of nursing personnel, including relief personnel who work on each unit for each tour of duty. This Statute is not met as evidenced by: Based on record review, observations and staff interviews for seven (7) of 29 sampled residents and one (1) supplemental resident, it was determined that sufficient time was not provided to each resident as evidenced by failure to: obtain stool samples for testing for one (1) resident; administer a supplement and sliding scale insulin as ordered for one (1) resident; follow up on recommendations to discontinue a supplement and change a diet for one (1) resident; elevate one (1) resident 's feet as ordered; consistently administer orange juice to one (1) resident as ordered; obtain a chest x-ray for one (1) resident; obtain a current order for palm protectors and review and discontinue orders not currently in use for one (1) resident; and obtain an order for bilateral hand orthotics for one (1) resident. Residents #2, 5, 9, 16, 21, 23, 26 and W1 The findings include:	L 055	L 055 3211.4 Nursing Facilities 1. The facility cannot retrospectively administer pro-source or insulin for Resident #5; the insulin order was clarified. Resident # 9 is now on a Carbohydrate Controlled Mechanical Soft diet and the dietary supplement Med Pass 2.0 120cc. BID orders have been discontinued. Resident #16 feet were elevated immediately. Resident #21 was reassessed by the clinical team in consultation with the MD and orders were clarified if indicated. The facility cannot retrospectively administer Orange Juice. This resident has not exhibited any signs/symptoms of hypoglycemia. Resident #26 and W1 were re-assessed by the clinical team. In consultation with the MD, the orthotic device and palm protector were clarified to meet the needs of the residents respectively. Nursing re-assessed resident #2, and in consultation with MD did additional follow up lab work . Resident #23 had a chest x-ray done. The chest x-ray was negative. 2. All residents in the facility with orders to elevate feet, diabetics with sliding scale, and orthotic devices were reviewed to ensure compliance. The dieticians have reviewed diet order changes to ensure full compliance. The 11-7 shift will be responsible for checking orders on a nightly basis. They will ensure the accuracy of the orders as well as ensure that new orders have been transcribed accurately. There were no other residents found to be affected by this practice. All residents with occult blood orders was audited to ensure completion of lab tests. All resident charts was reviewed for completion of chest x-ray orders. There were no other residents found to be affected by this practice.	

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L 055	<p>Continued From page 3</p> <p>1. Facility staff failed to obtain stool specimens for testing as ordered by the physician for Resident #2.</p> <p>A significant change MDS (Minimum Data Set dated June 6, 2006 included the diagnoses of Anemia under Section I.</p> <p>The physician's orders read as follows: June 2, 2006, "Stool guaiac q day (everyday) x3 days." June 13, 2006, "Stool guaiac Q daily x3 days." June 17, 2006, "Stool guaiac q daily x3."</p> <p>A review of the TAR (Treatment Administration Record) for June 2006 revealed either initials or "0" entered for June 3 through 5, June 14 through 16 and June 18 through 20, 2006.</p> <p>A review of the nurses' progress notes revealed that a stool specimen was collected on June 19 and 20, 2006, both of which were noted to be negative for blood. There was no evidence in the record of other stool specimens collected.</p> <p>A face-to-face interview was conducted on July 13, 2006 at approximately 10:00 AM with the Licensed Practical Nurse whose initials are entered on the TARs and the unit manager who acknowledged that only two (2) specimens were obtained on June 19 and 20, 2006. The record was reviewed on July 12, 2006.</p> <p>2. Facility staff failed to administer Prosource and administer insulin per physician's orders for Resident #5.</p> <p>A. A review of Resident #5's record revealed a physician's order signed May 2, 2006,</p>	L 055	<p>3. Licensed nurses will be in-serviced on how to correctly check monthly MD orders, MAR and TAR. The in-service will also include how to properly transcribe new orders. The monthly POS (Physicians Order Sheets), MAR and TAR will be signed by the nurse who checks them and who is verifying their accuracy. In addition staff has been educated on monitoring elevation of feet as ordered, documentation of sliding scale, and to monitor orthotic devices as ordered. The dietician will review the medical records and dietary Kardex within 72 hours to ensure that the dietary recommendations have been implemented.</p> <p>4. At the beginning of each month the DON, ADON or RCC, and Nursing Management will be responsible for reviewing a sample of the POS, MAR and TAR for accuracy. The nurse managers also will be reviewing charts weekly to ensure transcriptions are being taken off correctly. The physician orders, MAR, TAR and lab is also a part of the Quality Assurance program. This information is provided to the Quality Assurance team.</p>	08/13/06

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L 055	<p>Continued From page 4</p> <p>"Prosource 30ml three times daily."</p> <p>A review of the May, June and July Medication Administration Records (MAR) revealed that the order for the Prosource had not been transcribed or administered to the resident.</p> <p>A face-to-face interview was conducted with the charge nurse on July 11, 2006 at 12:25 PM. He/ she acknowledged that the Prosource had not been transcribed or administered to the resident.</p> <p>B. A review of Resident #5's record revealed a physician's order signed May 2, 2006, "Insulin coverage: [For blood sugar] 51-100 =8 oz of orange juice. 101-150 =0 units, 151-200= 2 units [insulin]. 201-250=4 units...twice daily."</p> <p>A review of the June and July MAR revealed the following: "51-100 = 8 ounces of orange juice. 101-151=200=2 units ..." There was no evidence in the record that the physician had changed the insulin order. There was no evidence in the record that facility staff clarified the above order for June 2006. On the July 2006 MAR was a hand written clarification, " 101-150 - 0 units; 151-200 = 2 units."</p> <p>Two (2) units of insulin were administered for blood sugars between 101 and 150 for 15 times for June 2006.</p> <p>Although the order was corrected for July 2006, two (2) units of insulin were administered for blood sugars between 101 and 150 for nine (9) times.</p> <p>There was no evidence in the record that the resident experienced any untoward effects from the inconsistency of insulin administration.</p>	L 055		

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L 055	<p>Continued From page 5</p> <p>A face-to-face interview was conducted with the nursing supervisor on July 12, 2006 at 12:25 PM. He/she stated that nursing staff should have corrected the order. The record was reviewed July 12, 2006.</p> <p>3. The dietician failed to follow up on a recommendation to change a diet order and licensed staff failed to discontinue an order for a supplement for Resident #9.</p> <p>A. The dietician failed to follow up on a recommendation to change Resident #9's diet order.</p> <p>Resident #9 was admitted to the facility on May 18, 2006. Admission orders included: "Carbohydrate controlled diet and Med Pass 2.0 2 X daily between meals for additional protein."</p> <p>A dietary progress note included the following: "May 25, 2006 ...Resident has uncontrolled DM (Diabetes mellitus), impaired vision and a few teeth. Place on Mech (mechanical) Soft diet for chewing purposes ..."</p> <p>The Interim Order Form included the following order: "June 16, 2006 at 3:00 PM, Please change diet, Carbohydrate Controlled diet to Mech Soft/Carbohydrate Controlled diet due to chewing difficulty."</p> <p>The dietician failed to follow up on the recommendation to change the diet; the diet wasn't changed until 22 days later. The record was reviewed July 11, 2006.</p> <p>B. Licensed staff failed to discontinue an order for the supplement Med Pass as ordered</p>	L 055			

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L 055	<p>Continued From page 6</p> <p>A dietary progress note included the following: " June 21, 2006, Residents weight changed since admission on 5/18/06 (169 lbs) and reweighed on 6/1/06 (191 lbs) resident was reweighed again to verify new weight. Adjustment of 500 calories for weight reduction. D/C (discontinue) Med Pass 2.0 due to weight gain and albumin of 3.4 ... Meal intake very good eats approximately 80-90% of meals."</p> <p>The Interim Order Form included the following orders: " June 16, 2006 at 3:00 PM, Please change diet, Carbohydrate Controlled diet to Mech Soft/Carbohydrate Controlled diet due to chewing difficulty " and " Recommend D/C Med Pass 2.0 120 cc BID (two times a day) due to resident weight gain Albumin 3.4."</p> <p>A review of the MARs/TARs (Medication Administration Record/Treatment Administration Record) for June 2006 and July 1 through 11, 2006 indicated [entry of licensed nurse's initials for each day at 10:00 AM and 6:00 PM] that Med Pass was administered.</p> <p>A face-to-face interview was conducted with the Unit Manager on July 11, 2006 at 10:50 AM. He/ She acknowledged that Med Pass was not discontinued as ordered by the physician.</p> <p>4. Facility staff failed to elevate Resident #16's feet while sitting as ordered by the physician.</p> <p>A review of Resident #16's record included the following orders on the June 2006 physician's order form: "November 20, 2003 [initial order date], Keep feet elevated while sitting and in bed to decrease edema" and "October 7, 2004 [initial order date], when in w/c (wheelchair), bend foot</p>	L 055			

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L 055	<p>Continued From page 7</p> <p>rest up so that leg is only supported by calf rest."</p> <p>The resident was observed on July 11, 2006 from 1:45 PM to 3:45 PM seated in a wheelchair in front of the nurses' station. There was a brace on the left leg and both feet were on the floor. The wheelchair did not have footrests. The unit secretary stated that the resident's w/c was broken.</p> <p>The resident was observed on July 12, 2006 at 2:10 PM in the w/c with both feet on the floor.</p> <p>A face-to-face interview was conducted with the Director of Rehabilitation on July 12, 2006 at 4:28 PM concerning the resident's broken wheelchair. He/She stated, "The chair was broken this month. We submitted a 719A form and sent it to Medicaid. We are waiting to hear. We have extra parts here for wheelchairs. If there is an issue with a wheelchair, they [nursing staff] can call me and I can get the part." The record was reviewed on July 11, 2006.</p> <p>5. A review of Resident #21's record revealed that the facility staff failed to consistently administer orange juice according to physician's orders for blood sugar levels between 51-100 g/dl</p> <p>A review of the May and June 2006 Medication Administration Record revealed, a physician's order which directed, "...Fingerstick twice daily with sliding scale coverage: - ...51-100: OJ [if the blood sugar level is between 51-100 give the resident orange juice]"</p> <p>There were nine (9) days in May 2006 and six (6) days in June 2006 that the resident should have received orange juice for blood sugar levels within the coverage range. Additionally, the May</p>	L 055		

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L 055	<p>Continued From page 8</p> <p>and June 2006 nursing notes had no documented evidence of orange juice being administered when indicated by the physician's order.</p> <p>A face-to-face interview was conducted on July 13, 2006 at 10:25 AM with the Resident Care Coordinator. He/she acknowledged that the MARs did not reflect the resident receiving the orange juice in accordance with the physician's order. The record was reviewed July 13, 2006.</p> <p>6. Facility staff failed to obtain a chest x-ray for Resident #23 as per physician's orders.</p> <p>A review of Resident #23's record revealed a physician's order dated May 2, 2006, "CXR - for aspiration pneumonia in 1 week." There was no evidence in the record that the chest X-ray had been completed at the time of this review.</p> <p>A face-to-face interview with the unit manager was conducted on July 12, 2006 at 10:45 AM. He /she stated, "[Resident #23] was transferred to another unit right after the order was written. I guess the chest X-ray got missed." The record was reviewed July 12, 2006.</p> <p>7. Facility staff failed to obtain an order for a palm protector and discontinue an order for braces that were not in use for Resident #26.</p> <p>A. Facility staff failed to obtain an order for a palm protector.</p> <p>A care plan for the problem "Requires supportive device related to contracture as evidenced by splint left hand" was initiated on September 7, 2005.</p> <p>The resident was observed in a wheelchair on</p>	L 055		

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L 055	<p>Continued From page 9</p> <p>July 12, 2006 at 2:55 PM. He/She had a palm protector on the left hand.</p> <p>A review of the current physician's order form for May 2006 lacked evidence of an order for a palm protector. The record was reviewed on July 12, 2006.</p> <p>B. Facility staff failed to discontinue an order for bilateral knee splints.</p> <p>The current physician's order form dated May 2006 included the following order: "11/11/04 [initial order date], Functional Maintenance Program for nursing staff to apply knee brace (black) Tues and Thurs and Abductor brace (green) M-Fri - Always check skin."</p> <p>The resident was observed in a wheelchair on July 12, 2006 at 2:55 PM. He/She was not wearing a knee splint. The resident stated, "I don't wear splints on my legs. I don't have leg splints. I had them several years ago. I did get a new wheelchair and didn't need them."</p> <p>An occupational therapy screening form dated June 27, 2006 indicated: "Comments: Pt (Patient) continues to wear Lt (left) palm protector appropriately. Independent in wheelchair mobility. No change in self care or functional mobility status. Occupational therapy evaluation not indicated."</p> <p>A face-to-face interview was conducted with the restorative aide on July 12, 2006 at 3:00 PM. He/She stated, "I started four months ago. I've only seen him with a palm protector." The record was reviewed on July 12, 2006.</p> <p>8. Facility staff failed to include an order for</p>	L 055		

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L 055	Continued From page 10 Resident W1's bilateral orthotic devices on the current physician's order form. An interim order form revealed the following order : "3/23/06, [initial order date], (B) (Bilateral) wrist hand finger ortho for hand contractures." This order was not included on the current physician's order form. The current physician's order form dated June 2006 included the following order: "8/25/05 [initial order date], Pt (patient) issued custom R-hand splint for contracture management, to be worn every day while out of bed ..." The resident was observed on July 13, 2006 at 7:56 AM with a splint on the left hand. A face-to-face interview was conducted with the CNA on July 13, 2006 at 7:56 AM. He/she was asked where the right hand splint was. The CNA stated, "It is missing. We don't know what happened to it. They [nursing staff] are ordering one." The record was reviewed on July 13, 2006.	L 055		
L 083	3216.4 Nursing Facilities Physical restraints shall not be applied unless: (a)The facility has explored or tried less restrictive alternatives to meet the resident's needs and such trails have bene documented in the resident's medical record as unsuccessful; (b)The restraint has been ordered by a physician for a specified period of time; (c)The resident is released, exercised and toileted at least every two (2) hours,except when	L 083	L 083 3216.4 Nursing Facilities 1. During the survey time Resident #15 was released and repositioned as required. The Interdisciplinary team (IDT) re-evaluated the restraint and it was determined that the seatbelt is still needed. The care plan was reviewed. The Treatment Administration Record (TAR) cannot be retrospectively altered for Resident #15 for June 26- June 30 and July 1- July 12. The TAR has been updated to include an on and off time schedule. 2. All residents on restraints were reviewed. There were no other residents found to be affected by this practice. 3. Nursing personnel were re-educated on the restraint policy and documentation. 4. All residents with restraints will be reviewed monthly in the Quality Improvement (QI) sub committee. This is a part of the QI program. Review of the flow sheets (TAR sheets) is a part of nursing comprehensive medical records audit. The findings are reported to the Quality Assurance Committee.	08/13/06

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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 083	<p>Continued From page 11</p> <p>a resident's rest would be unnecessary disturbed.</p> <p>(d)The use of the restraint doe not result in a decline in the resident's physical, mental psychological or functional status; and</p> <p>(e)The use of the restraint is assessed and re-evaluated when there is a significant change in the resident's condition.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review for one (1) of 29 sampled residents, facility staff failed to follow the physician's order for releasing a restraint and repositioning the resident for 16 days. Resident #15.</p> <p>The findings include:</p> <p>A review of Resident 15's record revealed a telephone order dated June 26, 2006 at 12:20 [PM] and signed by the physician on July 7, 2006 which directed, "Seatbelt for safety. Staff to release seatbelt q 2 hrs (every two hours) and reposition resident for 15 min [minutes] ..."</p> <p>A review of the June and July 2006 Treatment Administration Record [TAR] revealed, "Staff to release seatbelt and reposition resident q 2 hrs for 15 minutes". The order was dated June 26, 2006. The TAR was not initialed [would indicate that the seatbelt was released every two (2) hours and that the resident was repositioned] for June 26 (3- 11 shift) and 27 through 30, 2006 and July 1 through 12, 2006.</p> <p>A face-to-face interview was conducted on July 12, 2006 at 11:42 AM with the Unit Manager. He/ she acknowledged that the physician's order to release the seatbelt and reposition the resident was not initialed from June 26 (3-11 shift) to July</p>	L 083		

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L 083	Continued From page 12 12, 2006. The record was reviewed on July 12, 2006.	L 083		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that shower seats and a geri chair were not cleaned thoroughly after use by residents. These findings were observed in the presence of Housekeeping, Maintenance and Nursing Staff. The findings include: 1. Two (2) of three (3) shower chairs were observed on unit 4 South at 4:00 PM on July 12, 2006 soiled with a dark brown substance. 2. A geri chair in room 201 was observed at approximately 8:00 AM on July 12, 2006 with a dark brown substance in one (1) of one (1) observation.	L 091	L 091 3217.6 Nursing Facilities 1. The two shower chairs were cleaned and disinfected on July 12, 2006, by the housekeeping supervisor. The geri chair was cleaned by the certified nursing assistant, then disinfected by the housekeeping staff. 2. All shower chairs were inspected for cleanliness and disinfected as needed. No resident was affected by this finding. 3. Shower chairs will be checked daily for cleanliness by the housekeeping personnel, Supervisor and Director of the department. 4. The corrective plan will be monitored by all personnel of the housekeeping department and daily routine checks will be made by the Supervisor and Director. This will be reported to the Quality Assurance committee.	7/31/06
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services;	L 128		

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L 128	Continued From page 13 (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, interview and record review for three (3) of 29 sampled residents and two (2) supplemental residents, the pharmacist failed to complete a monthly drug regimen review . Residents #5, 16, 19, J1 and J2. 1. The pharmacist failed to complete a drug regimen review for Resident #5 for June, 2006. A review of Resident #5's "Chronological Record of Drug Regimen Review" revealed that the last date the pharmacist reviewed the resident's record was May 15, 2006. There was no evidence that the pharmacist had completed a June 2006 review. A face-to-face interview with the unit manager was conducted on July 11, 2006 at 12:25 PM. He /she acknowledged that a drug regimen review should have been completed for June 2006. The	L 128	L 128 3224.3 Nursing Facilities 1. Residents #5,16,19,J1, and J2 cannot be retrospectively corrected however, the residents were seen by the pharmacist and the drug review was completed. 2. The consultant pharmacist compared the facility census with the drug review report and found no other residents affected by this deficient practice. 3. The consultant pharmacist will obtain a copy of the facility census when completing monthly drug reviews to ensure no missing reviews. 4. The consultant pharmacist audit will include the pharmacy section of the medical record and will be reported at the Quality Assurance meeting.	8/20/06

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L 128	<p>Continued From page 14</p> <p>record was reviewed July 11, 2006.</p> <p>2. A review of Resident #16's record revealed that the pharmacist failed to perform a drug regimen review for January 2006. The pharmacist drug regimen review form indicated that a review was performed on December 19, 2005 and the following review was dated February 27, 2006. There was no evidence of a drug regimen review performed for January 2006. The record was reviewed on July 11, 2006.</p> <p>3. A review of Resident #19's record revealed that the pharmacist failed to perform a drug regimen review for June 2006.</p> <p>There was a drug regimen review in the record for May 2006.</p> <p>A face-to-face interview was conducted with the unit manager on July 12, 2006 at 11:45 AM who acknowledged the lack of a June 2006 pharmacist drug regimen review. The record was reviewed on July 12, 2006.</p> <p>4. A review of Resident J1's record revealed that the pharmacist failed to perform the drug regimen review for June 2006.</p> <p>A review of Resident J1s "Chronological Record of Drug Regimen Review" revealed that the pharmacist reviewed the resident's record in May 2006. There was no evidence that the pharmacist completed a June 2006 review.</p> <p>5. A review of Resident J2's record revealed that the pharmacist failed to perform the drug regimen review for June 2006.</p> <p>A review of Resident J2's "Chronological Record</p>	L 128		

Revised
8/16/06

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L 128	Continued From page 15 of Drug Regimen Review" revealed that the pharmacist reviewed the resident's record in May 2006. There was no evidence that the pharmacist completed a June 2006 review.	L 128		
L 214	<p>3234.1 Nursing Facilities</p> <p>Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled HVAC panel and filters, inoperative water fountains in the hallways, soiled ceiling tiles in residents' rooms and common areas, marred entrance and bathroom doors, excessive personal items on floors and on top of cabinets in residents' rooms, soapy residue on shower walls, damaged geri chair armrests and soiled exhaust vents. These findings were observed in the presence of the Maintenance, Housekeeping and Nursing Staff.</p> <p>The findings include:</p> <p>1. The interior surfaces of HVAC (Heating Ventilation and Air Conditioning Units) control panels and filters were soiled with accumulated dust in residents' rooms and common areas in the following areas:</p> <p>First Floor Room 102, Day Room and hallway in three (3) of eight (8) observations between 2:35 PM and 4:15 PM on July 11, 2006.</p>	L 214	<p>L 214 3234.1 Nursing Facilities</p> <p>1. The soiled HVAC panels and filters were cleaned immediately by the housekeeping porter during the survey period. Inoperative water fountains in hallways were removed, soiled ceiling tiles in residents rooms and common areas were replaced. Marred entrance and bathroom doors, damaged geri chair armrests, shower room walls and soiled exhaust vents were removed or cleaned. Excessive boxes were removed from the following rooms: 200, 208, 231, 300 and 317</p> <p>2. All HVAC panels and filters were cleaned and replaced as needed. All water fountains were inspected and/ or repaired. All residents rooms were inspected for soiled ceiling tiles and replaced as needed. All entrance and bathrooms doors were inspected and painted as needed. All geri chair armrest pads were inspected and repaired as needed. All exhaust vents were inspected and cleaned. All shower walls and rooms were checked on the units for soapy residue and excessive items. No resident was affected by this practice.</p> <p>3. The Director of Engineering reviewed the Prevention Maintenance program and re-Educated staff on expectations. Ceiling tiles, shower walls, resident rooms and geri-chair inspections are included on daily room inspections. The Engineering and Environmental personnel will be in-serviced on these as well.</p> <p>4. The Director of Engineering will conduct quarterly audits on the HVAC panels /filters and the exhaust vents. Monthly audits will be conducted on water fountains, soiled ceiling tiles, shower walls, resident rooms, marred entrance and bathroom doors and geri chairs. Findings will be presented at the Quality Assurance meeting.</p>	8/28/06

Health Regulation Administration

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L 214	Continued From page 16 Second Floor Rooms 201, 231, Day Room, Dining Room and hallway in five (5) of eight (8) observations between 7:55 AM and 9:30 AM on July 12, 2006. Third Floor Day Room and Dining Room in two (2) of six (6) of observations between 2:30 PM and 2:55 PM on July 12, 2006. Fourth Floor Rooms 400, 427, Day Room and Dining Room in four (4) of 10 observations between 3:00 PM and 4:30 PM on July 12, 2006. 2. Water fountains in the hallways were observed to be inoperative when examined on floors one (1) through four (4) in seven (7) of seven (7) observations between 7:55 AM and 4:30 PM on July 12, 2006. 3. Ceiling tiles in residents' rooms were soiled and stained and failed to fit into grids securely in the following areas: First Floor Room 106 in one (1) of eight (8) observations at approximately 2:45 PM on July 11, 2006. Second Floor Rooms 201, 222 and janitorial closet in three (3) of six (6) observations between 7:55 AM and 9:30 AM on July 12, 2006. Third Floor Rooms 300 and 324 in two (2) of six (6) observations between 2:30 PM and 2:55 PM on July 12, 2006. Fourth Floor Rooms 416, 431 and janitorial closet in three (3) of eight (8) observations between 3:00 PM and 4:30 PM on July 12, 2006.	L 214			

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L 214	<p>Continued From page 17</p> <p>4. Residents' entrance and bathroom doors and doors jams were marred and splintered on the edges in the following areas:</p> <p>First Floor Rooms 121 and 122 in two (2) of eight (8) observations between 2:35 PM and 4:35 PM on July 12, 2006.</p> <p>Second Floor Rooms 203, 207, 208, 211 and 222 in five (5) of six (6) observations between 7:55 AM and 9:30 AM on July 12, 2006.</p> <p>Third Floor Day Room in one (1) of six (6) observations at approximately 2:45 PM on July 12, 2006.</p> <p>5. Excessive personal items were observed in residents' rooms on the floor, in boxes, on top of closets, paper bags and suitcases in rooms 200, 208, 231, 300 and 317 in five (5) of 15 observations between 7:55 AM and 4:30 PM on July 12, 2006.</p> <p>6. The lower surfaces of shower walls were observed to have a soapy residue in the following areas:</p> <p>Second Floor in four (4) of four (4) observations between 7:55 AM and 9:30 AM on July 11, 2006.</p> <p>7. Geri chair armrests were marred and damaged in residents' rooms and common areas.</p> <p>Second Floor Room 201 and Day Room in two (2) of five (5) observations between 7:55 AM and 9:30 AM on July 12, 2006.</p> <p>Fourth Floor Room 424D in one (1) of eight (8) observations between 3:00 PM and 4:30 PM on July 12, 2006.</p>	L 214			

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L 214	Continued From page 18 8. The interior surfaces of exhaust vents were soiled with accumulated dust and debris in residents' rooms and common areas. First Floor Room 106 and soiled linen room in two (2) of eight (8) observations between 2:35 PM and 4:35 PM on July 11, 2006. Second Floor shower room and janitorial closet in two (2) of eight (8) observations between 7:55 AM and 9:30 AM on July 12, 2006. 9. Laundry detergent such as Extra and a gallon of Tide were in open view on shelves in residents' rooms 200 and 431 in two (2) of two (2) observations between 9:00 AM and 4:15 PM on July 12, 2006.	L 214		
L 235	3236.4 Nursing Facilities The temperature of hot water of each fixture that is used by each resident shall be automatically controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). This Statute is not met as evidenced by: Based on observations during the survey, it was determined that boilers and mixing valves were not adjusted to ensure that hot water temperatures did not exceed 110 degrees Fahrenheit (F). These findings were observed in the presence of Maintenance, Housekeeping and Nursing Staff. The findings include: Second Floor Dining Room-116 degrees F, 2 South Shower Room 119 degrees F and 217-114 degrees F in three (3) of eight (8) observations	L 235	L 235 3236.4 Nursing Facilities 1. The boilers and mixing valves that were identified have been adjusted and corrected to read between 100 – 105 degrees Fahrenheit (F). 2. Domestic water temperatures throughout the facility have been inspected and adjusted to read between 100 – 105 degrees Fahrenheit (F). No residents were affected by this finding. 3. The boilers and mixing valves used to maintain domestic water temperatures will be inspected twice daily as part of the Engineering daily and evening maintenance rounds. Discrepancies in water temperatures will be corrected immediately. 4. The Director of Engineering will monitor and conduct monthly audits of the domestic water temperatures and report all findings at the Quality Assurance meeting.	7/31/06

Health Regulation Administration

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L 235	Continued From page 19 between 7:55 AM and 9:30 AM on July 12, 2006. Third Floor Room 300-119 degrees F in one (1) of eight (8) observations between 2:45 PM and 3:30 PM on July 12, 2006.	L 235		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that flies, gnats and mosquitoes were observed on seven (7) of seven (7) nursing units. The findings include: Flies, gnats and mosquitoes were observed throughout the building during the survey period in the following areas: Unit 1 North: 8:30 AM on July 11, 2006, 7:45 AM and 3:30 PM on July 12, 2006 and 7:15 AM and 1:45 PM on July 13, 2006. Unit 1 South: 9:15 AM and 2:30 PM on July 11, 2006, 11:00 AM on July 12, 2006 and 7:05 AM and 12:00 PM on July 13, 2006. Unit 2 North: 2:00 PM on July 11, 2006, 11:55 AM on July 12, 2006 and 10:30 AM on July 13, 2006. Unit 2 South: 9:00 AM and 1:15 PM on July 11, 2006, 10:30 AM and 3:45 PM on July 12, 2006 and 9:15 AM on July 13, 2006.	L 426	L 426 3257.3 Nursing Facilities 1. Engineering staff will ensure that all window screens are properly fitted. The curtain fan on the One South exit door to the courtyard was checked and is in proper working condition. 2. Nursing and housekeeping personnel will identify residents who hoard food, fruits and liquids. Personnel will remove all food items from their rooms as needed. 3. Western Pest Control was notified of the problem and an extra service was performed of the facility. 4. Western Pest Control will monitor the problem and notify the Housekeeping Director of any concerns. The Housekeeping Director will also monitor the environment and report findings to the Quality Assurance Committee.	8/13/06

Health Regulation Administration

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L 426	<p>Continued From page 20</p> <p>Unit 3 South: 8:55 AM and 2:00 PM on July 11, 2006, 8:30 AM and 2:45 PM on July 12, 2006 and 9:00 AM and 2:00 PM on July 13, 2006.</p> <p>Unit 4 North: 8:30 AM and 1:20 PM on July 11, 2006, 8:00 AM and 2:00 PM on July 13, 2006 and 9:20 AM and 11:30 AM on July 13, 2006.</p> <p>Unit 4 South: 8:45 AM and 2:00 PM on July 11, 2006, 9:45 AM and 3:30 PM on July 12, 2006 and 10:10 AM and 1:45 PM on July 13, 2006.</p> <p>Gnats were observed in the board room on the lower level throughout the survey period. Residents access this level for banking.</p> <p>It was observed on July 11, 12 and 13, 2006 between 7:00 AM and 8:15 AM that the inner and outer courtyard doors were locked in an open position. The doors did not open or close automatically.</p> <p>A face-to-face interview was conducted with the Director of Security on July 13, 2006 at 7:15 AM. He/she stated that the night security guard was responsible for unlocking the courtyard doors. He stated, " The doors should not be locked open, but automatically open and close. "</p>	L 426		

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

PRINTED: 07/26/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2006
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NAME OF PROVIDER OR SUPPLIER J B JOHNSON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW WASHINGTON, DC 20001
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K 000 INITIAL COMMENTS
The Life Safety Code inspection was conducted at your facility on July 14, 2006. A deficiency was cited based on observations.

K 017 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5

This STANDARD is not met as evidenced by:
Based on observations during the Life Safety Code inspection, it was determined that smoke barrier walls were not in good condition to prevent the passage of smoke in the event of a fire.

The findings include:

A 12" x 10" opening was observed in wall surfaces above the material management door at 9:30 AM on July 14, 2006.

J. B. Johnson
2006
JB Johnson
Fire
2006

2. A complete inspection of fire barrier walls have been conducted by (3) independent contractors, proposals to make necessary repairs have been submitted to the Director of Engineering by each contractor and submitted to DHS. No residents were affected by this finding.

3. The Engineering Department will inspect the fire barrier walls monthly as part of the monthly Preventive Maintenance program. All findings will be reported to the Director of Engineering.

4. The Director of Engineering will monitor and conduct quarterly audits of the fire barrier walls and report all findings at the Quality Assurance meeting.

8/11/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Annette Price</i>	TITLE Administrator	(X6) DATE 8/4/06
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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.

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

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NAME OF PROVIDER OR SUPPLIER J B JOHNSON NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 017	<p>Continued From page 1</p> <p>A 18" x 4" opening was observed in wall surfaces over the boiler room door in one (1) of one (1) observation at 9:40 AM on July 14, 2006.</p> <p>A 1-2" opening was observed around two pipes in wall surfaces adjacent to the dishwasher in one (1) of five (5) observations at approximately 10:00 AM on July 14, 2006.</p> <p>A 2" opening was observed around a pipe above double doors in the basement hallway in one (1) of two (2) observations at 10:05 AM on July 14, 2006.</p> <p>A 5" opening was observed in the wall above double doors in the elevator lobby in one (1) of two (2) observations at 10:10 AM on July 14, 2005.</p> <p>A 1-2" opening was observed around communication wires and conduit pipe that pass through walls on the clean side of the laundry room in one (1) of two (2) observations at 10:15 AM on July 14, 2006.</p>	K 017		