

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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NAME OF PROVIDER OR SUPPLIER  <b>J B JOHNSON NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 FIRST STREET NW WASHINGTON, DC 20001</b>
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L 000	Initial Comments  An annual licensure survey was conducted on May 7 through 9, 2007. The following deficiencies were based on record review, observations, and interviews with facility staff and residents. The sample included 29 residents based on a census of 193 residents on the first day of survey and two (2) supplemental residents.	L 000	<b>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.</b>	
L 031	3207.6 Nursing Facilities  The physician shall prescribe a planned regimen of medical care which includes the following:  (a) Medications and treatments;  (b) Rehabilitative services;  (c) Diet;  (d) Special procedures and contraindications for the health and safety of the resident;  (e) Resident therapeutic activities; and  (f) Plans for continuing care and discharge. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 29 sampled residents, it was determined that the physician failed to write an order to decrease the Dilantin dosage for Resident #17 after acceptance of the pharmacist's recommendation.  The findings include:  A review of Resident #17's pharmacy consultant dated February 27, 2007 revealed the following recommendation: "...Suggest decreasing dose of Dilantin and rechecking level in 7 days."	L 031	<b>L 031 3207.6 Nursing Facilities</b>  1. The attending physician for resident #17 has reassessed the resident. The physician's orders have been updated to address Dilantin dose. No adverse reaction was noted to the resident.  2. All pharmacy recommendations were reviewed to ensure physician orders were written. There were no other residents affected by this practice.  3. All attending physicians were re educated on how to properly accept or deny pharmacy recommendations and follow through with a physician order based on the recommendation.  4. The consultant pharmacist reports the acceptance or denial of recommendations quarterly at the Quality Assurance meeting.	6/8/07

Health Regulation Administration

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

*Administrator* TITLE

(X6) DATE  
*5/29/07*

Health Regulation Administration

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L 031	Continued From page 1  Further review revealed that the physician signed the recommendation on March 2, 2007 and placed a check mark next to "Accept recommendation " in the section entitled "Doctor Response." Included in the section entitled, "Doctor Response" is the notation, "Please write any new orders on a physician's order sheet."  A review of the record lacked evidence of an order to decrease the Dilantin dosage after March 2, 2007.  A face-to-face interview with Unit Manager #7 was conducted on May 7, 2007 at approximately 2:40 PM. He/she acknowledged that the order to decrease the Dilantin dosage was not written by the physician and there was no further follow up. The record was reviewed May 7, 2007.	L 031		
L 051	<b>3210.4 Nursing Facilities</b>  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;	L 051	<b>L 051 3210.4 Nursing Facilities</b>  1. Resident #2 follow up consult was scheduled on April 30 <sup>th</sup> , the results were read on May 3 <sup>rd</sup> and signed by the physician on May 7 <sup>th</sup> . Resident #3 care plan was updated to reflect appropriate interventions and goals for falls and the adverse effects of 9 or more medications. Resident # 5 care plan was updated to reflect goals and approaches for wound care and the adverse effects of 9 or more medications. Residents #14 and #20 care plan was updated to reflect goals and approaches of anticoagulant therapy. The care plan for resident #16 was updated to reflect goals for the pacemaker. Resident #18 care plan was updated to reflect appropriate interventions and goals for falls, the use of 9 or more medications and resisting care, the psychiatric consult was obtained March 28 <sup>th</sup> . Resident #19 care plan was updated with approaches to the resident's refusal to wear a smoking apron. Resident #25 care plan was updated with new goals for attempting to elope. Resident #26 care plan was updated to reflect goals and approaches for the diagnosis of seizure disorder. A physician order was obtained for resident JH2 to crush medications.	

Health Regulation Administration

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L 051	<p>Continued From page 2</p> <p>(e)Supervising and evaluating each nursing employee on the unit; and</p> <p>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review for three (3) of 29 sampled residents and one (1) supplemental resident, it was determined that the charge nurse failed to ensure that a follow-up consult was scheduled for one (1) resident with a history of a subdural hematoma; update the falls care plan with additional goals and approaches to prevent further falls for two (2) residents; initiate care plans for the potential adverse drug interactions from the use of nine (9) or more medications for three (3) residents, a pressure ulcer for one (1) resident, two (2) residents for the use of anticoagulants, one (1) resident with a pacemaker, two (2) residents for resisting care, one (1) resident who attempted to elope from the facility and one (1) resident with a diagnosis of seizure disorder; obtain a psychiatric consult timely for one (1) resident; and follow facility policy prior to crushing medications for one (1) resident. Residents #2, 3, 5, 14, 16, 18, 19, 20, 25, 26 and JH2.</p> <p>The findings include:</p> <p>1. The charge nurse failed to ensure that a follow-up consult was scheduled for Resident #2.</p> <p>The March 26, 2007, "Report of Consultation" revealed a request by the attending physician " F/U Subdural hematoma [hospital name] (April)"</p> <p>A review of the record failed to show evidence of a follow up consult for Subdural hematoma for</p>	L 051	<p><b>L 051 3210.4 Nursing Facilities Continue</b></p> <p>2. Physician requested consults, psychiatric consults and residents taking crushed medications were reviewed for appropriate MD orders and follow through. Care plans for all residents with 9 or more medications, wounds, on anticoagulant therapy, having a pacemaker, refusing care, attempting to elope and diagnosis of seizure disorder were reviewed and updated as needed. The care plan for all residents with a fall in the last quarter was reviewed. No other resident were affected by this practice.</p> <p>3. Nursing personnel was re educated on following up on consultation reports, obtaining a physician's order before crushing medications, proper documentation of goals and approaches for falls, and the importance of ensuring care plans are developed, implemented and followed.</p> <p>4. Consults have been added to the medical record audit tool and physician orders added to the nurse audit tool. Fall care plans are reviewed during the monthly "Falls meeting" and is part of the Continuous Quality Improvement Program. Additionally, focus audits of care plans following a fall will be incorporated into the audit. The comprehensive care plan is audited monthly. The information will be presented at the Quality Assurance Meeting.</p>	6/22/07

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L 051	<p>Continued From page 3</p> <p>April 2007.</p> <p>A face-to-face interview was conducted with Unit Manager #6 on May 7, 2007 at 4:00PM. He/she stated, "The follow-up was never scheduled." The record was reviewed on May 7, 2007 at 2:00 PM.</p> <p>2. The Charge Nurse failed to update Resident #3's care plan for falls and initiate a care plan with appropriate goals and approaches for potential adverse drug interactions from the use of nine (9) or more medications .</p> <p>A. A review of the nurses' note dated March 4, 2007 at 3:00 PM, revealed, "...Resident was observed on the floor in the courtyard on (lt) [left] side lateral position. Upon assessment no injury noted at this time. Physician [ ] and RP [ ] made aware. Will continue to monitor ..."</p> <p>Resident #3's record revealed an undated care plan for "Resident at risk for falling ..." There was no evidence that additional goals and approaches were developed in response to the resident's March 4, 2007 fall.</p> <p>A face-to-face interview was conducted with Unit Manager #2 on May 7, 2007 at 1:00 PM. He /she acknowledged that Resident # 3 ' s care plan was not updated to reflect additional goals and approaches in response to the above cited fall.</p> <p>B. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches for potential adverse drug interactions from the use of nine (9) or more medications .</p> <p>A review of Resident #3's record revealed a physician's order dated and signed April 4, 2007</p>	L 051		

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L 051	<p>Continued From page 4</p> <p>which prescribed the following : Ascriptin, Cogentin, Lasix, OS-Cal, Potassium Chloride, Risperdal, Trazodone, Vitamin E, Tylenol, Vitamin A and D.</p> <p>The IDT (Interdisciplinary) care plan last reviewed April 25, 2007 failed to include appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications.</p> <p>A face-to-face interview was conducted with Unit Manager #2 on May 7, 2007, at 1:00 PM. He / She acknowledged that Resident # 3's care plan did not include goals and approaches for the potential adverse drug interactions involving nine (9) or more medications . The record was reviewed May 7, 2007.</p> <p>3. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications and a pressure ulcer to the lower back for Resident #5.</p> <p>A. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications</p> <p>Review of Resident #5's record revealed a physician's order sheet dated May 2007 that included the following medications: Carbamazepine, Keppra, Levothyroxine, Lipitor, Nexium, Warfarin, Ascorbic Acid, Folbee, OsCal, Vitamin B6, and Zinc Sulfate.</p> <p>A review of the IDT care plan, last updated April 11, 2007, failed to include a care plan with</p>	L 051		
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L 051	<p>Continued From page 5</p> <p>appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications.</p> <p>B. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches for a pressure ulcer to the lower back</p> <p>A review of Resident #5's weekly pressure ulcer healing record revealed, upon admission March 13, 2007, an unstageable open area to the lower back measuring 1.9 x 2.5 x 0.5 cm.</p> <p>On May 8, 2007 at 9:00 AM the pressure ulcer to lower back was observed in the presence of the unit manager.</p> <p>A review of the IDT care plan, last updated April 11, 2007, lacked evidence of goals and approaches for the pressure ulcer to the lower back.</p> <p>A face-to-face interview with Unit Manager #5 was conducted on May 8, 2007 at approximately 12:16 PM. He/she acknowledged the lack of a care plan for the potential adverse drug interactions for 9 (nine) or more medications and the pressure ulcer to the lower back. The record was reviewed May 8, 2007.</p> <p>4. The Charge Nurse failed to initiate a care plan with goals and approaches for Resident #14 who received anticoagulant therapy.</p> <p>The April 2007 Physician's Order Sheet signed by the physician on April 5, 2007 revealed " E C (enteric coated) Aspirin 325 mg 1 tab PO (by mouth) every day for prophylaxis "</p> <p>The significant change MDS (Minimum Data Set)</p>	L 051		

Health Regulation Administration

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L 051	<p>Continued From page 6</p> <p>in Section I included diagnoses of PVD (Peripheral Vascular Disease) and other CVD (Cardiovascular Disease)</p> <p>A review of the IDT care plan failed to show evidence of appropriate goals and approaches for the daily use of EC Aspirin.</p> <p>A face-to-face interview was conducted with Unit Manager #5 on May 8, 2007 at 3:00 PM. He/she acknowledged that there was no care plan for EC Aspirin use in the record. The record was reviewed on May 8, 2007.</p> <p>5. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches for Resident #16's pacemaker.</p> <p>A review of Resident #16's record revealed that the resident was admitted on November 14, 2006. According to the admission Minimum Data Set assessment, in Section I, "Disease Diagnoses", the resident was coded for a pacemaker.</p> <p>An assessment of the function of the pacemaker was done on April 12, 2007 and present in the record at the time of this review.</p> <p>The resident's IDT care plan was last reviewed February 15, 2007. There was no evidence that facility staff initiated a care plan with appropriate goals and approaches for the pacemaker.</p> <p>A face-to-face interview with Unit Manager #2 was conducted on May 8, 2007 at 8:15 AM. He/she acknowledged that there was no care plan for the pacemaker. The record was reviewed May 8, 2007.</p>	L 051		

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L 051	<p>Continued From page 7</p> <p>6. The Charge Nurse failed to update the care plan with appropriate goals and approaches for Resident #18 who had multiple falls, the behavior of resisting ADL (Activities of Daily Living) care and for the potential adverse drug interactions from the use of nine (9) medications and ensure that a psychiatric consult was conducted timely.</p> <p>A. The Charge Nurse failed to update the care plan with appropriate goals and approaches for Resident #18 who had multiple falls.</p> <p>A review of Resident #18's nursing notes revealed the following:</p> <p>April 10, 2007 at 3:00 PM - "...Found [resident] on the floor in a sitting position in the hallway ..."</p> <p>April 17, 2007 at 6:00 AM - "...Resident in a sitting position inside the room ..."</p> <p>A review of the "Potential for Injury/fall" care plan last updated April 7, 2007 failed to address the above mentioned falls with new goals and approaches to prevent further falls.</p> <p>A face-to-face interview with Unit Manager #3 was conducted on May 7, 2007 at approximately 3:50 PM. He/she acknowledged that the care plan did not address the aforementioned falls.</p> <p>B. The Charge Nurse failed to initiate a care plan with appropriate goals and interventions for Resident's #18's behavior of resisting ADL care.</p> <p>The resident was admitted to the facility on January 9, 2007. A review of the quarterly Minimum Data Set (MDS) dated April 19, 2007 and the admission MDS dated January 18, 2007 revealed that the resident was coded in Section,</p>	L 051		

Health Regulation Administration

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L 051	<p>Continued From page 8</p> <p>E4, Behavioral Symptoms, as resisting care.</p> <p>The care plan, last reviewed April 11, 2007, did not include the resident's behavior of resisting care.</p> <p>A face-to-face interview was conducted with Unit Manager #1 on May 9, 2007 at 11:15 AM. He/She stated, "[Resident] gets agitated. They can't give [resident] a shower when [he/she] is agitated." He/she acknowledged the lack of a care plan for resisting ADL care.</p> <p>A face-to-face interview was conducted with CNA #1 on May 8, 2007 at 12:15 PM. CNA #1 is frequently assigned to care for the resident. He/she stated, "[Resident] fights me and I can't give [him/her] a shower ..."</p> <p>C. The Charge Nurse failed to initiate a care plan with appropriate goals and interventions for the potential adverse drug interactions from the use of nine (9) or more medications.</p> <p>A review of the May 2007 Physician's Order Sheet, signed May 6, 2007, was inclusive of the following medications: Aricept, Lipitor, Lisinopril, Lorazepam, Metformin, Cogentin, Risperdal, Depakote and Haldol. The origination dates of the aforementioned medications were January 10 through May 3, 2007.</p> <p>The IDT care plan was last reviewed on April 11, 2007 and did not include problem identification for potential for adverse drug interactions from the use of nine (9) or more medications.</p> <p>A face-to-face interview was conducted with Unit Manager #3 on May 9, 2007 at 11:15 AM. He/She acknowledged the lack of a care plan for</p>	L 051		

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L 051	<p>Continued From page 9</p> <p>nine (9) or more medications and the potential for adverse drug interactions. The record was reviewed on May 8, 2007.</p> <p>D. The Charge Nurse failed to ensure that a psychiatric consult was conducted timely for Resident #18.</p> <p>A review of Resident #18's Physician Order Sheet dated January 9, 2007 and signed by the physician revealed, "...Psychiatric Consult for Agitation..." and a physicians order dated March 4, 2007 revealed, "...Psychiatric Consult, indication: Depression and Dementia with Psychosis. "</p> <p>A review of the record failed to show evidence of a psychiatric consult for January or February 2007.</p> <p>A consultation for "Evaluation for mental status and agitated behavior" signed by the consulting psychiatrist was dated March 28, 2007.</p> <p>The record lacked evidenced that a psychiatric consult was obtained as ordered by the physician on January 9, 2007. In addition, the second psychiatric consult that was ordered on March 4, 2007 was not obtained until March 28, 2007, 24 days after the order.</p> <p>A face-to-face interview with Unit Manager #3 was conducted on May 7, 2007 at approximately 3:50 PM. He/she acknowledged the psychiatric consults that were ordered on January 9 and March 4, 2007 were not completed until March 28, 2007. The record was reviewed May 7, 2007.</p> <p>7. The Charge Nurse failed to initiate a care plan for Resident #19 who refused to wear a smoking</p>	L 051		

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L 051	<p>Continued From page 10</p> <p>apron while smoking in the courtyard.</p> <p>A review of the nurses' notes revealed the following:</p> <p>March 21, 2007 [no time indicated]: "Reported that resident has a wound on the right inner thigh ... Resident on assessment was asked what caused the wound, [he/she] said, while [he/she] was smoking some time last week that the cigarette fell in between [his/her] thighs. When asked if any one witnessed it and if [he/she] reported it to the courtyard monitor at that time when it happened, [he/she] said, 'No'..."</p> <p>April 11, 2007 at 3:15 PM: "...Resident was observed putting [his/her] cigarette with flame in a plastic bag in the wheel chair and started bringing fire which the reporter said [he/she] put it off [out] immediately."</p> <p>A face-to-face interview was conducted on May 9, 2007 at approximately 1:00 PM with Resident #19. He/she stated, "No, I don't use anything over me when I smoke. I don't need anything." The resident denied that the above mentioned incidents occurred.</p> <p>A face-to-face interview with Unit Manager #1, Director of Nursing and the Administrator was conducted on May 9, 2007 at approximately 3:00 PM. They stated, "The resident has a diagnosis of Schizophrenia and is delusional. We tried to put the apron on [him/her] but [he/she] didn't wear it. They acknowledged that there was no care plan in place to address the resident's refusal of wearing the smoking apron.</p> <p>The record lacked evidence that a care plan was initiated to address the resident's refusal to wear</p>	L 051		

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L 051	<p>Continued From page 11</p> <p>a smoking apron while smoking. The record was reviewed May 9, 2007.</p> <p>8. The Charge Nurse failed to include goals and approaches for the use of Coumadin on the care plan initiated for anticoagulant therapy for Resident #20.</p> <p>Resident #20 was prescribed three (3) anticoagulant medications, Aspirin, Plavix and Coumadin, on March 14, 2007. During the review of the care plan dated March 23, 2007 for anticoagulant therapy, it was observed that goals and approaches for the use of Coumadin was not included.</p> <p>On May 8, 2007 at approximately 11:00 AM, a face-to-face interview was conducted with Unit Manager #1 who acknowledged that Coumadin was not included in the care plan. The record was reviewed on May 8, 2007.</p> <p>9. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches for Resident #25 who had multiple elopement attempts.</p> <p>A review of the nurse's notes revealed the following:</p> <p>April 14, 2007 at 11:00 PM, "...aggressive behavior trying to leave the facility with a bag ..."</p> <p>April 15, 2007 at [no time indicated], " Resident came out again. Ignored everybody and went to elevator. Writer called security and they stopped [him/her] and brought [him/her] back to the unit..."</p> <p>April 17, 2007 at 10:00 PM, "...[he/she] is at the lobby at this time with his/her belongings. Stated</p>	L 051		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 051	<p>Continued From page 12</p> <p>he/she wants to go home..."</p> <p>A review of the IDT care plan last updated March 19, 2007, lacked problem identification of the resident's attempts to elope from the facility.</p> <p>A face-to-face interview with Unit Manager #5 was conducted on May 8, 2007 at approximately 12:16 PM. He/she acknowledged that a care plan for elopement should have been initiated after the three (3) attempts of elopement in April, 2007. The record was reviewed May 8, 2007.</p> <p>10. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches to address Resident #26's diagnosis of Seizure disorder.</p> <p>During the review of the resident's record, the physician's orders signed and dated March 22, 2007 included, " Gabapentin 100mg 1 cap by mouth two (2) times a day for seizure" [origination date of March 8, 2007].</p> <p>The IDT care plan dated March 19, 2007 lacked problem identification with approaches and goals for the diagnosis of Seizure disorder.</p> <p>On May 9, 2007 at approximately 10:00 AM, a face-to-face interview was conducted with Unit Manager #5 who acknowledged that a care plan for Seizure disorder should have been initiated. The record was reviewed on May 9, 2007.</p> <p>11. The Charge Nurse failed to follow facility policy prior to crushing medications for Resident JH2.</p> <p>According to the facility's Policy 5.3.3, "Crushing of Medications" stipulates, "All medication which</p>	L 051		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 051	<p>Continued From page 13</p> <p>do not lose effectiveness, or produce side effects when crushed, may be crushed per physician's order for residents who have difficulty swallowing medications."</p> <p>On Tuesday, May 8, 2006, at approximately 10:25 AM, the medication nurse (employee #7) was observed crushing a Hydralazine 50 mg tablet and a Multivitamin with Iron tablet for Resident JH2. The resident swallowed the enteric coated Aspirin with water that had a thickening agent added. A total of three (3) medications were administered to the resident. There were no untoward effects to the resident.</p> <p>The Physician Orders and the Medication Administration Record lacked evidence of an order to crush medication.</p> <p>A face-to-face interview was conducted with the medication nurse [Charge Nurse #1] on May 8, 2007, at 10:20 AM. He/she stated that the resident does not swallow properly and that it was a nursing judgement to crush the medicines.</p>	L 051	<p><b>L 052 3211.1 Nursing Facilities</b></p> <ol style="list-style-type: none"> <li>1. Resident #19 was immediately added to the courtyard monitoring list of residents to closely monitor while smoking.</li> <li>2. Residents needing additional assistance in the courtyard and all smokers were reassessed for smoking safety.</li> <li>3. The interdisciplinary team and personnel on the residents' unit were in-serviced regarding the residents' need. The resident is included on the courtyard monitoring list as needing more supervision while smoking.</li> <li>4. The quality assurance tool was updated and will be reported at the Quality Assurance Meeting.</li> </ol>	6/22/07
L 052	<p><b>3211.1 Nursing Facilities</b></p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers;</p> <p>(c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as</p>	L 052		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 052	Continued From page 14  evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;  (d) Protection from accident, injury, and infection;  (e) Encouragement, assistance, and training in self-care and group activities;  (f) Encouragement and assistance to:  (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;  (2) Use the dining room if he or she is able; and  (3) Participate in meaningful social and recreational activities; with eating;  (g) Prompt, unhurried assistance if he or she requires or request help with eating;  (h) Prescribed adaptive self-help devices to assist him or her in eating independently;  (i) Assistance, if needed, with daily hygiene, including oral care; and  (j) Prompt response to an activated call bell or call for help.  This Statute is not met as evidenced by: Based on observation, record review, staff and resident interview for one (1) of 29 sampled residents, it was determined that sufficient nursing time was not given to prevent accidents and injury to Resident #19, who was identified as requiring increased supervision in the courtyard	L 052		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 052	<p>Continued From page 15</p> <p>while smoking.</p> <p>The findings include:</p> <p>A review of the nurses' notes revealed the following:</p> <p>March 21, 2007 [no time indicated]: " Reported that resident has a wound on the right inner thigh ... Resident on assessment was asked what caused the wound, [he/she] said, while [he/she] was smoking some time last week that the cigarette fell in between [his/her] thighs. When asked if any one witnessed it and if [he/she] reported it to the courtyard monitor at that time when it happened, [he/she] said, "No ..."</p> <p>April 11, 2007 at 3:15 PM: "...Resident was observed putting [his/her] cigarette with flame in a plastic bag in the wheel chair and started bringing fire which the reporter said [he/she] put it off immediately."</p> <p>The care plan, last reviewed April 11, 2007, included the approach of closely monitoring Resident #19 while in the courtyard and smoking. The record lacked evidence that increased monitoring of the resident occurred when the resident was in the courtyard.</p> <p>A face-to-face interview was conducted on May 9, 2007 at approximately 1:00 PM with Resident #19. He/she stated, "No, I don't use anything over me when I smoke. I don't need anything." The resident denied that the above mentioned incidents occurred.</p> <p>A face-to-face interview was conducted on May 9, 2007 at 3:00 PM with CNA #2. He/she was</p>	L 052		
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 052 Continued From page 16

asked which residents required increased monitoring or supervision while in the courtyard. CNA #2 named five (5) residents that required increased monitoring. Resident #19's name was not included in the five (5) residents named by CNA #2.

A face-to-face interview with Unit Manager # , the Director of Nursing and the Administrator was conducted on May 9, 2007 at approximately 3:15 PM. They stated, "The resident has a diagnosis of Schizophrenia and is delusional. We don't know where [he/she] got the blister. We went through [his/her] clothes and we did not find any burn holes in the clothing. We tired to put the apron on [him/her] but [he/she] didn't wear it. We looked in the bag and there were no cigarettes or ashes in the bag. We could not substantiate the incidents." The record was reviewed May 9, 2007.

L 052

L 099 3219.1 Nursing Facilities

Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by soiled sheet pans, deep fryer and floor surfaces. These findings were observed in the presence of the Food Service Director.

The findings include:

1. The inner and bottom surfaces of sheet pans

L 099

**L 099 3219.1 Nursing Facilities**

1. The inner and outer surfaces of sheet pans were cleaned and sanitized immediately. The deep fryer exterior surfaces, inner panels, electrical wiring, gas lines and floor surfaces under the fryer was cleaned and sanitized.
2. All sheet pans and other cooking equipment was inspected and determined that no other equipment or utensils were affected. No resident was affected by this practice.
3. The Director of Food Service met with the dietary personnel and they were re educated regarding this practice.
4. Monthly, a quality sanitation audit form will be completed. The Director of Food Services and/or designee will monitor the sanitation of the kitchen daily. The results will be presented at the Quality Assurance Meeting.

6/15/07

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 099	Continued From page 17  were soiled with a greasy film after washing in the pot and pan wash sink in six (6) of 17 observations of sheet pans at approximately 4:00 PM on May 7, 2007.  2. Deep fryer exterior surfaces, inner panels, electrical wiring, gas lines and floor surfaces under the fryer were soiled with accumulated grease in one (1) of one (1) observation of the deep fryer and floor surfaces at 9:00 AM on May 7, 2007.  The Food Service Director acknowledged the aforementioned findings at the time of the observations.	L 099		
L 157	3227.8 Nursing Facilities  Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition.  This Statute is not met as evidenced by: Based on observation, review of Monthly Unit Inspection reports and staff interview, it was determined that facility staff failed to store all drugs and biologicals under proper temperature controls in one (1) of seven (7) medication refrigerators.  The findings include:  On May 7, 2007, at approximately 10:00 AM, during the inspection of the medication storage	L 157	<b>L 157 3227.8 Nursing Facilities</b>  1. The medication refrigerator on 2 North was serviced to maintain a temperature within the required range of 36 to 46 degrees.  2. All medication refrigerators were inspected and no other refrigerators were out of range.  3. Maintenance personnel were re educated on how to service the refrigerator units and proper temperature ranges.  4. Checking the medication temperatures is a part of the daily nursing and monthly pharmacy inspections. This is also now included in the engineering inspections. This information will be presented at the Quality Assurance meeting.	6/8/07

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 157	Continued From page 18  area on 2 North, the medication refrigerator ' s thermometer reading was 50 degrees Fahrenheit (F).  On May 7, 2006, during the review of the Monthly Unit Inspection reports from the consultant pharmacist, it was noted that the medication refrigerator on 2 North fluctuated out of range in six (6) of the ten (10) monthly unit inspections from July 2006 through April 2007.  The Monthly Unit Inspection reports had the following temperatures documented for the following months : April 2007 - 50° F, January 2007 - 50° F, December 2006 - 50° F, November 2006 - 50° F, October 2006 - 50° F and August 2006 - 50° F.  A face-to-face interview was conducted with Charge Nurse #4. He/She stated that he/she was not aware that the medication refrigerator's temperatures were out of range.	L 157		
L 161	3227.12 Nursing Facilities  Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation and staff interview for one (1) of seven (7) nursing units, it was determined that facility staff failed to ensure that expired medication was removed from usage. Unit 4 North.  The findings include:  On Monday, May 7, 2007, at approximately 9:30 AM, during the inspection of the facility's emergency boxes, emergency box #34A on Unit 4 North contained two (2) Vitamin K 10mg/ml	L 161	<b>L 161 3227.12 Nursing Facilities</b>  1. The emergency box on 4 North was exchanged and replaced.  2. All emergency boxes on all the units were inspected for missing or expired medications by the Woodhaven Pharmacist. No other boxes were found to be deficient of this practice.  3. Nursing personnel was re educated on the use of supplies from the emergency boxes. The pharmacy will check contents of the emergency boxes monthly.  4. The pharmacist checks the emergency boxes as part of the pharmacy inspections. This information will be presented at the Quality Assurance Meeting.	6/22/07

Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER  <b>J B JOHNSON NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 FIRST STREET NW WASHINGTON, DC 20001</b>		
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L 161	Continued From page 19  ampules with an expiration date of May 1, 2007. The emergency box's expiration date was documented as May 30, 2007.  A face-to-face interview was conducted with Charge Nurse #3. He/she stated that the emergency box was never opened. The box was observed to be locked with a yellow plastic lock. Charge Nurse #3 stated that the pharmacy supplies the yellow locks and that the facility would put a red lock on the box if it was opened by facility staff.  Facility staff failed to remove the two (2) expired Vitamin K ampules from the emergency box.	L 161		
L 306	3245.10 Nursing Facilities  A call system that meets the following requirements shall be provided:  (a) Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents;  (b) In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room;  (c) Be of a quality which is, at the time of installation, consistent with current technology; and  (d) Be in good working order at all times.  This Statute is not met as evidenced by: Based on observations and staff interviews for six (6) of seven (7) nursing units, it was determined	L 306	<b>L 306 3245.10 Nursing Facilities</b>  1. Amplified buzzers were installed to the enunciator panels to increase the alarm sound on 6 of the 7 nursing units. The sound of the call bell was retested and heard on May 22, 2007 by the environmental surveyor.  2. All 6 units alarm sound was amplified. When the remaining unit is upgraded the amplifier will be installed. No resident was affected.  3. Engineers will conduct random nurse call system tests to ensure that it is functioning properly.  4. The nurse call system is a part of the nursing audit and is presented at the Quality Assurance meeting.	5/22/07

Health Regulation Administration

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L 306	<p>Continued From page 20</p> <p>that portions of the facility's call system failed to function.</p> <p>The findings include:</p> <p>During the initial tour conducted on May 7, 2007, at 8:45 AM, it was observed that, when activated, the call bell could not be heard when in resident rooms 119 through 123. This observation was made in the presence of Unit Manager #5.</p> <p>On May 9, 2007 from 6:40 AM through 7:00 AM and 9:30 AM through 10:10 AM, a tour of all the facility's units was conducted to determine if activated call lights were audible throughout the unit. The following findings were noted:</p> <p>On Unit 1 North, the call light system was set for "low tone" at 6:45 AM and 9:30 AM. The call bell system was activated in room 109 at 6:45 AM in the presence of Charge Nurse #1. The call bell was activated in room 110 at 9:30 AM in the presence of Unit Manager #1. The call bell was not audible in either room or the hallway from room 109 through room 111 either time tested.</p> <p>On Unit 1 South, the call light system was activated in room 119 at 6:40 AM and room 122 in the presence of Unit Manager #4 and CNAs #3 and 4. The call bell was activated at 9:40 AM in the presence of CNA #5. The call bell was not audible in either room or the hallway from room 119 through room 123 either time tested.</p> <p>On Unit 2 North, the call light system was activated in room 207 at 7:05 AM in the presence of Unit Manager #2, Charge Nurse #2 and CNAs #5 and 6. The call bell was activated in room 208 at 9:42 AM in the presence of Unit Manager #2. The call bell was not audible in either room or the</p>	L 306		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2007</b>
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L 306	Continued From page 21 hallway from room 207 through room 214 either time tested.  On Unit 2 South, the call light system was activated in room 219 at 7:10 AM in the presence of CNAs #7 and 8. The call bell was activated in room 228 at 9:44 AM Charge Nurse #3. The call bell was not audible in either room or the hallway from room 219 through 234 either time tested.	L 306		