STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview for one (1) of 34 sampled residents, the facility's staff failed to ensure one (1) was free from physical restraint. (Resident #108) Findings included . The facility's staff failed to ensure Resident #108 was free from physical restraint. Observation on 03/11/20 at 10:00 AM of Resident #108's showed the resident lying in bed in supine position with head of bed elevated at 45-degree angle with both side (long) side rails up. Interview with the resident at the time of observation revealed that he was alert and oriented to name only. A second observation on 03/11/20 at 2:00 PM of Resident #108's room revealed the resident was asleep lying in bed in supine position with head of bed elevated at 45-degree angle with both side (long) side rails up. A third observation with Employee #10, Unit Manager, on 03/11/20 at 3:00 PM of Resident #108's room showed the resident lying in bed with both side (long) side rails up. Review of Resident #108's current medical record on 03/11/20 at 3:10 PM showed the resident was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Continued review of the record showed there was no documented evidence of a physician order [REDACTED].#10, Unit Manager stated that the side rails should not have been elevated. Employee #10 acknowledged the finding during the face-to-face interview. Review of Resident #108's current medical record on 03/11/20 at 3:30 PM showed the resident was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Continued review of the record showed there was no documented evidence of a physician order [REDACTED].#108 was free from physical restraints.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview for one (1) of 34 sampled residents, the facility's staff failed to ensure one (1) resident's Care Plan was revised. (Resident #7). Findings included . Review of Resident #7's current medical record on 03/07/20 at 11:00 AM showed that the resident was admitted [DATE]. The resident was noted to have multiple [DIAGNOSES REDACTED]. During an interview on 03/06/20 at 10:00 AM, Resident #7 stated, I have concerns with my transportations arrangements to [MEDICAL CONDITION]. The last time I went to my [MEDICAL CONDITION] appointment. I had to pay for my transportation, but they (nursing home) paid me back. Further review of the Resident #7's medical record revealed a Care Plan with a last care conference date of 02/28/20. The Care Plan failed to outline who was responsible for making Resident #7's transportation arrangements to and from [MEDICAL CONDITION] treatments. During a face-to face interview on 03/07/20 at 2:00 PM, Employee #11, Unit Manager, stated, I did not update the Care Plan with transportation arrangements because transportation arrangements are in the progress notes. Employee #11 acknowledged the finding during thee face-to-face interview. The facility's staff failed to revise Resident #7's Care Plan to include who was responsible for making transportation arrangements to and from [MEDICAL CONDITION] treatments.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview for three (3) of 34 sampled residents, facility staff failed to show evidence of monitoring one (1) resident for specific behaviors to include: confusion, anxiety, agitation and restlessness, to monitor one (1) resident's side effects with the use of a [MEDICAL CONDITION] medication, and to provide evidence that one (1) resident was monitored while receiving Antipsychotic medications. Residents' #39, #93 and #120. Findings included . 1.Resident #39 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Comprehensive Minimum Data Set ((MDS) dated [DATE], showed Section C-Cognitive Patterns: Brief Interview for Mental Status resident was scored as 10 which indicate cognition is moderately intact. Section D (0100) Mood was coded a 1 to indicate resident's mood interview was conducted and there were no symptoms present. Section E: Behavior (E0100. Potential for [MEDICAL CONDITION]), check all that apply A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli), B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality). None of the above box was marked with an X to indicate the resident did not exhibit those behaviors. Review of the physician's orders [REDACTED]. Review of Psychiatric Notes showed the following: On 8/20/19 note reads: Resident seen for Psych follow up secondary to use of Duloxetine 40mg cap PO daily for depression and [MEDICATION NAME] 0.5 mg tablet PO daily for Anxiety, restlessness and agitation, resident met in bed alert to self and place, able to make needs known, calm and cooperative. Reported to be occasionally agitated, Plan continue with use of Duloxetine 40mg cap PO daily and [MEDICATION NAME] 0.5 mg tablet PO daily Revaluate in 1-2 months and PRN On 12/2/19 note reads: Resident seen for Psych evaluation secondary to dx (diagnoses) of depression and anxiety and use of Duloxetine 40mg cap PO daily for depression and [MEDICATION NAME] 0.5 mg tablet PO daily for Anxiety/agitation. Resident seen and evaluated on unit. Alert and cooperative, able to follow commands but confused, unable to indicate time day or who the president is. Occasional agitation reported by staff. Taking Duloxetine and [MEDICATION NAME] without any adverse reaction, Plan continue with use of Duloxetine 40mg cap PO daily for depression and [MEDICATION NAME] 0.5 mg tablet PO daily for Anxiety/agitation Reassess in 1-2 months or as needed On 3/7/20 note reads: Resident seen for Psych follow up secondary to use of Duloxetine 40mg cap PO daily in AM and [MEDICATION NAME] 0.5 mg tablet PO daily in AM for restlessness and agitation, Met with patient in the day area on wheelchair she appears alert but confused and agitated unable to state her age, place of birth, time and place. Plan continue with use of Duloxetine 40mg for depression and [MEDICATION NAME] 0.5 mg for agitation and restlessness and revaluate in 1-2 months/PRN Review of the current nursing care plan last updated 1/9/20, showed the Focus: Psychoactive drug use (resident name) has Potential for adverse medication side effects, related to: Anxiety use - [MEDICATION NAME], Antidepressant use - [MEDICATION NAME] (Duloxetine HCL); Interventions: administer meds as ordered and notify medical staff of adverse effects. There is no evidence that facility staff updated the care plan to addressed behavior monitoring (confusion, anxiety, agitation and restlessness) for the resident. Review of the Medication Administration Record [REDACTED]. During a face-to-face interview on 3/12/20 at 10:00 AM, Employee #3 was shown the Medication Administration Record [REDACTED]. Employee #3 responded we are monitoring for behaviors, but we do not have monitoring sheets for behaviors. Employee #3 acknowledged the findings at the time of the record review. 2.Review of Resident #93's current medical record on 03/11/20 at 2:00 PM showed that the resident was admitted on [DATE] with several [DIAGNOSES REDACTED]. Continued review of Resident #93's current medical record showed Medical Administration Records (MARs) from 12/01/19 to 03/10/19 that revealed the resident was administered Quetiapine (Anti-psychotic) 50mg one table by mouth at 9:00 PM daily. Further review of the resident's medical record revealed [REDACTED].#93 for the side effects of Quetiapine an anti-psychotic medication. During a face- interview on 03/11/20 at 2:30 PM, Employee #10, Unit Manager,

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) acknowledged the finding. The facility's staff failed to monitor Resident #93's for side effects of Quetiapine an anti-psychotic medication. 3. Resident #120 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of a quarterly Minimum data set (MDS) dated [DATE] showed that the resident was coded for the use of Antipsychotics in Section N0410 Medications received. However, review of the clinical record and the MAR for January through March 11, 2020 failed to show documented evidence that the resident was being monitored for the use of Antipsychotic medication. During a face-to-face interview on March 11, 2020 with Employee #3 the employee acknowledged that there was no documented evidence to show that the resident was monitored while she was receiving the Antipsychotic medication.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, it was determined that facility staff failed to prepare food in accordance with professional food safety standards as evidenced by two (2) of two (2) grease fryers that were soiled with leftover fried food residue, six (6) of seven (7) soiled, six-inch deep, one-quarter pans that were stored on a clean, ready-for-use shelf, and one (1) of one (1) four-inch deep pan and one (1) of one (1) one-eight pan that were dented throughout. Findings included . 1. Two (2) of two (2) grease fryers were soiled were soiled with fried food residue. 2. Six (6) of seven (7) six-inch deep, one-quarter pans stored on a clean ready-for-use shelf were not thoroughly clean. 3. One (1) of one (1) four-inch deep pan and one (1) one-eight pan were dented throughout. These findings were acknowledged by Employee #18 on March 5, 2020, at approximately 10:30 AM.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that facility staff failed to maintain the call bell system in good condition as evidenced by one (1) of 30 call bell that failed to alarm as expected. Findings included . During an environmental walkthrough of the facility on March 5, 2020, the call bell in resident room [ROOM NUMBER]A did not alarm when tested , one (1) of 30 call bells tested . This deficiency could prevent or delay clinical care to a resident in an emergency. These findings were acknowledged by Employee #16 and Employee #17 on March 6, 2020, at approximately 10:00 AM.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on record review and interview for one (1) of three (3) sample certified nursing assistants, the facility staff failed to ensure a certified nursing assistant received Dementia Management Training in 2019. Finding included . Record review of Employee #19, CNA, personnel record on 03/11/20 at 3:00 PM showed the employee's date of hire was 02/06/17. Continued review of the record lacked documented evidence Employee #19 had Dementia Management Training in 2019. During a face-to-face interview on 03/11/20 at 3:30 PM, Employee #20, Inservice-Coordinator acknowledged the finding. The facility staff failed to ensure that Employee #19 had annual training on Dementia Management in 2019.