STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 093300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2026

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A0000	INITIAL COMMENTS An unannounced Federal complaint and facility reported incident survey was conducted at Children's National Hospital from 09/29/2026 to10/09/2026. The facility's census was 281 on the first day and 285 on the last day of survey. The sample size was 20 patients. Deficiencies were cited related to the investigation of intakes C-3400794. No deficiencies were cited related to intakes C3692417 and C3400791. There were incidental findings.	A0000		
A0144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is NOT MET as evidenced by: Based on hospital policy review, medical record review, and interview, the facility ' s nursing staff failed to conduct and document direct safety continuous observation (1:1) per policy for one (1) out of 10 patients sampled (Patient #8) Findings Include: A review of the facility's Continuous Therapeutic Observation and Monitoring" policy, last updated 08/20/2025 revealed "Once the need for 1:1 direct observation is identified, a direct observer will be provided per provider orders or per protocol orders. Direct Observer: Provide 1:1 direct observation of the patient at all times. The patient may not be left unattended at any time. Provide 1:1 direct observation of the patient until relieved by another staff member. 3. Documentation of 1:1 Direct Observation: During the 1:1 direct observation period (at approximately every 4 hours and as needed: The presence of the direct observer, the patient's location, the patient's behaviors, Care delivered within scope of practice and based on patient care needs.	A0144		

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 reverse for further 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.

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

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A0144	Continued from page 1 A review of Patient #8's medical record on 09/25/2026 from 04:14 AM to 07:00 PM, revealed patient #8 came to the ED with chief complaint of increased aggression and according to Patient # 8's mother, "mom reports that 2 [two] days ago, pt [Patient #8] had a 45 min episode at school where [They] was not responsive to others, was drooling, and exhibiting violent behavior. Pt does not remember this happening. At OSH [Outside Hospital], pt [Patient#8] was pacing and banging his head on the wall. Drug screen was negative for everything except cannabis". Further review of the nurse's triage notes on 09/25/2026 at 04:14 AM revealed Patient #3 was assigned ESI level 3 in the Emergency Department ESI (Emergency Severity Index - A validated tool for performing a triage assessment to determine the patient's acuity and prioritization; Level 2 = emergent/high risk and Level 3 = urgent/stable). Further review of the ED provider's notes on 09/25/2026 at 06:13 AM revealed "Re-examination/Re-evaluation: Time 09/25/2026 06:13:00 AM, Notes Patient not responding to directions from staff to stop pacing or redirection. Further review of the ED physicians' orders on 09/25/2026 at 04:39 AM and 06:13 AM revealed "Safety Continuous Direct Observer (1:1) [one to one close observation of patient]. Further review of direct observer's notes on 09/25/2026 and flow sheet revealed no documentation of safety checks and close observation monitoring from 7:00AM to 07:00PM. The Surveyor conducted a face-to-face interview with Employee #16 ED Physician and Employee #22 ED Manager on 09/29/2026 at approximately 10:00AM and Employee# 22 acknowledged the lack of documentation of safety checks and 1:1 direct observation in the medical record of Patient #8. Employee # 16 state that [they] wrote the orders for 1:1 closed observation to protect the patient from potentially injuring other patients and a sitter should have been placed with the patient until the orders are discontinued. Employee #22 acknowledged that the patient was not placed with a sitter from 07:00 AM to 07:00 PM and no safety checks were documented.	A0144		
A0396	NURSING CARE PLAN CFR(s): 482.23(b)(4)	A0396		

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A0396	Continued from page 2 The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is NOT MET as evidenced by: Based on hospital policy review, medical record review, and interview, the facility ' s nursing staff failed to conduct the Interdisciplinary plan of care and vital sign assessments and per policy for five (4) out of 10 patients sampled (Patients #12, #13, #17, and #20). Findings Include: A review of the facility's "Nursing Admission Database &[and] Observation Patient Nursing Database Guidelines" policy last revised on 06/2025 revealed "General Guidelines... Plans of Care (POC) are reviewed and documented on every shift. Nursing progress notes are written when there are additional notes needed or identified patient problem in POC is not being met…All patients will have a minimum of 1[one] IPOC [Interdisciplinary Plans of Care] ordered with an IPOC addressing each major patient problem. Each IPOC has associated goals, interventions, indicators, and outcomes associated, which will be individualized to each patient. IPOC initiated within 12 hours of admission IPOC reviewed each shift. Each IPOC needs documentation of met/not met goals and interventions daily. Each nurse is responsible for documenting on an IPOC each shift." A review of Patient #12's medical record from 04/14/2026 to 06/06/2026 revealed Patient # 12 was "admitted for management of severe right ventricular systolic function. Further review of Patient #12's IPOC notes from 05/27/2026- 06/05/2026 revealed no IPOC documentation on the following dates: -05/01/2026 to 05/02/2026 -05/04/2026 -05/28/2026 to 05/31/2026 A review of Patient #13's medical record from 04/14/2026 to 06/05/2026 revealed Patient # 13 was admitted to CICU [Cardiac Intensive Care Unit] for close monitoring due to risk of decompensation from	A0396		

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A0396	Continued from page 3 abnormal heart beats and failure of heart valve. Further review of Patient #13's IPOC notes from 03/24/2026- 06/29/2026 revealed no IPOC documentation on the following dates: -04/1/2026 to 04/03/2026 -04/07/2026 to 04/14/2026 -04/17/2026 to 04/23/2026 -o4/23/2026 to 05/08/2026 -05/10/2026 to 05/18/2026 -01/06/2026 to 06/04/2026 -06/11/2026 to 06/25/2026 -06/27/2026 to 06/28/2026 A review of Patient #17's medical record from 04/20/2026 to 08/03/2026 revealed Patient # 17 was admitted to the Neonatal Intensive Care Unit for... prematurity, acute respiratory failure, respiratory distress syndrome, observation for sepsis [infections] and abnormal body temperature. Further review of Patient #17's IPOC notes from 07/10/2026- 08/03/2026 revealed no IPOC documentation on the following dates: -07/22/2026 -07/23/2026 A review of Patient #20's medical record from 04/25/2026 to 08/03/2026 revealed Patient # 20 was admitted to the Neonatal Intensive Care Unit with "prenatally diagnosed complex congenital heart disease… [They] is admitted for cardiac evaluation and prematurity." Further review of Patient #20's IPOC notes from 07/10/2026- 08/03/2026 revealed no IPOC documentation on the following dates: -07/14/2026 -07/16/2026 to 07/24/2026 -07/31/2026 The Surveyor conducted a face-to-face interview with Employee # 25, Manager NICU [Neonatal	A0396		

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A0396	Continued from page 4 Intensive Care Manager] and Employee # 28 PICU [Pediatric Intensive Care] Manager who acknowledged the lack of IPOCs on the dates identified on the patient's medical records. Employee # 25 and #28 acknowledged that IPOCs are to be documented on each shift and with changes with patient conditions with goals indicated "Achieved or Not Achieved and dated	A0396		
A0398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is NOT MET as evidenced by: Based on hospital policy review, medical record review, and interview, the facility ' s nursing staff failed to conduct vital sign assessments per policy for five (5) out of 10 patients sampled (Patients #3, # 4, #5, #6, and #7). Findings Include: A review of the facility ' s "Emergency Medicine and Trauma Center: Triage, Assessment and Reassessment dated December 10, 2024, revealed " B. Triage Assessment: • ESI (A validated tool for performing a triage assessment to determine the patient's acuity and prioritization) … ESI-Level Two (Yellow) - Charge nurse role immediately notified and patient given first available ED room. If room is not rapidly available, initial care may begin in assessment area. ESI-Level Three (Green) – Roomed strictly by time of arrival, unless change of condition warrants upgrading. Patients assigned an ESI level of three that should be seen sooner than other ESI three patients but do not meet criteria for ESI two can be noted as "Priority" or "Next back." E. Reassessment A repeat primary and focused secondary assessment is obtained and done documented at least every[four] 4-hours or at change of RN provider, for every patient, regardless	A0398		

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A0398	Continued from page 5 of complaint. Patients at risk for altered level of consciousness, hemodynamic instability, or receiving medications which may alter vital signs, are reassessed at least every hour Vital Signs Repeat vital signs are obtained and documented at minimum every four hours or when warranted by patient condition/clinical judgment and within 1 hour of any: Out of range measurement Medication administration that may affect vital sign stability ... “ Discharge/Transfer • Patients discharged from the ED [Emergency Department] will have a focused discharge assessment including heart rate and respiratory rate documented in the vital signs …if last documented blood pressure or temperature was abnormal, a repeat blood pressure or temperature must be charted at time of discharge. If any vital sign is abnormal at time of discharge, a full set of vital signs must be checked” A review of the facility ' s undated vital signs parameter revealed “Heart Rate, Respiratory Rate, Oxygen Saturation, Systolic/Diastolic… and Blood Pressure parameters will display out of range normal, high/low or critical high/low based on the age and gender of the patient… [For “age 7<8yo” [7YEARS BUT LESS THAT 8 YEARS] the critical high for BP [blood pressure] systolic[gender] is: Systolic 122 and Diastolic 83].” A review of Patient #3 's medical record form 09/18/2026 to 09/19/2026 revealed that Patient # 3 came to the ED (Emergency Department) with chief complaint of suicidal ideations stating: “I will kill myself every possible way” Further review of the ED triage notes on 09/19/2026 at 05:54 revealed Patient #3 had a full set of vital signs recorded and was assigned ESI (Emergency Severity index. A triage tool used to sort patients based on the urgency of their condition Level 2 = emergent/high risk and Level 3 = urgent/stable) level 2. Further review of the last nursing assessment prior to discharge on 09/19/2026 at 00:34 AM revealed no further blood pressure reassessment by the nurse. A review of Patient #4’s medical record from 09/23/20226 at 12:45PM to 09/24/2026 at 01:49 PM	A0398		

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A0398	Continued from page 6 revealed Patient 4 came to the ED with the chief complaint of suicidal ideation with a plan to jump off a balcony and assigned an ESI level 3. Further review of the ED vital signs reassessment on 09/23/2026 at 01:41 AM revealed the vital signs were done at 01:49 AM and no other sets of vital sign assessments were documented until 09/24/2026 at 08:50AM. A review of Patient #5's medical record from 09/28/2026 to 09/26/2026 revealed the patient came to the ED with chief complaint of suicidal ideation after ingesting 6 (six) to 10 400 mg (milligrams) of Motrin and was assigned ESI Level 2. Further review of the nurses' notes on 9/28/2026 revealed vital signs done at 05:56 PM and no other sets of vital signs assessments were documented until 09/29/2026 at 12:40 PM. A review of Patient #6's medical record from 09/18/2026 at 05:26 PM to 09/18/2026 at 22:16 PM revealed Patient #6 came to the ED with chief complaint of suicidal ideation. Further review of Patient #6 triage notes on 09/18/2026 at 05:30 PM revealed Patient #6 was assigned ESI level 3 Further review of the Physician's order on 09/18/2026 at 05:08 revealed "vital signs Routine Every 4 [four] hours…" Further review of the ED triage notes on 09/18/2026 at 05:30PM revealed "ED BP [Blood Pressure] Unable to Obtain: BP not indicated." with only one set of vital signs documented during the ED stay from 05:26 PM to discharge time at 10:16PM. A review of Patient 7's medical record from 09/28/2026 to 09/29/2026 revealed Patient # 7 came to the ED with chief complaint of altered mental health status, seizures and "patient also hypertensive in TR. [Triage] all other vitals stable." Patient #7is [age years] old and was assigned ESI Level 2. Further review of Patient # 7's Triage vital signs at 11:42 PM revealed an elevated blood pressure of 146/74.There was no reassessment within 1 (one) hour and every 4 (four)hours per policy. Further review of the ED vital signs records revealed the next vital signs after triage was conducted on 09/29/2026 at 05:53 PM.	A0398		

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A0398	Continued from page 7 The Surveyor conducted a face-to-face interview with Employee # 9 ED Manager on 09/29/2026 at approximately 10:00AM who acknowledged that vital signs entries in the patient records were not documented at the required intervals. Employee #9 Acknowledged that vital signs are expected to correspond to the patient's ages with deviations from normal Parameters assessed and reassessed as ordered or treated	A0398		
A0405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is NOT MET as evidenced by: Based on hospital, medical record review, and interview, the facility ' s medication administration record, nursing staff failed to administer a STAT (immediately) medication order with timeliness for one (1) out of 10 patients sampled (Patient #12) Findings include: A review of the facility's "Medication Policy dated 03/24/2026 revealed: "H. ADMINISTRATION… Time-Critical medications - Those where early or delayed administration of maintenance doses of greater the 30 minutes before or after the scheduled dose may cause harm or result in suboptimal therapy of pharmacological effect. Scheduled medications are considered Timed critical in the following instances: Time-critical scheduled	A0405		

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A0405	Continued from page 8 medications should be administered at the scheduled time, otherwise within 30 minutes before or after the scheduled time…" A review of Patient #12's medical record from 04/14/2026 to 06/06/2026 revealed Patient # 12 was "admitted for management of severe right ventricular systolic function... He requires ICU [Intensive Care Unit] level of care as he is at risk of cardiac arrest requiring inotropic [medications to change the force of the heart's contractions] support. Further review of Patient #12's medication administration record from 05/30/2026 at 10:35 AM: revealed an order to administer Spironolactone [a diuretic] 13.5 mg STAT at 10:32 AM. The medication was administered at 12:17 PM. The Surveyor conducted a face-to-face interview with Employee #4, the Vice President Chief, Quality and Employee #13, Director of Pharmacy on 09/30/2026 at approximately 10:43 AM who confirmed the medication policy did not include STAT orders. Employee#13 stated that STAT orders are expected to be administered within 15 to 30 munities of the STAT order being placed by the provider, Employee #4 stated that [they] will discuss the problem with the different teams.	A0405		