BRIDGEPOINT+
HEALTHCARE

07/28/2025 Sent via email 07/28/2025

Mrs. Kingsberry,
Program Manager
Office Of Healthcare Facilities Division
Health Regulation and Licensing Administration

RE: Form 2567 Plan of Correction and associated documents for April 13,2025—05/05/2025 Annual certification Survey (Provider #095027),

We are submitting our Plan of Correction, Form CMS-2567 for April 13th, 2025, Annual certification survey. In addition, the following documents are also included:

- Form CMS-2567 for our April 13th, 2025, Annual survey.

If you have any questions, please feel free to contact me via email at ooyekoya@bridgepointhealthcare.com or call me at 202-546-5700 (ofc) or 813-476-5443 (cell). Thank you.

Sincerely,

Olayinka Oyekoya, LNHA
Administrator
Bridgepoint Sub-Acute and Rehabilitation Capitol Hill

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0033	A. BUILDING: _____ B. WING _____	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB	223 7TH STREET NE WASHINGTON, DC 20002

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L 000	Initial Comments An unannounced Long Term Care Annual Licensure Survey was conducted at this facility April 13, 2025, through May 5, 2025. The survey activities consisted of a review of 49 sampled residents. The following deficiencies are based on observations, record reviews and resident and staff interviews. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations Chapter 32 for Nursing Facilities. The resident census on the first day of the survey was 100 and the facilities license capacity is 117. The following complaints were investigated during this survey: DC00012731, DC00012762, DC00012779, DC00012781, DC00012827, DC00012998, DC00013039, DC00013090, DC00013282, DC00013498, DC00013624 and DC00013628. The following facility reported incidents were investigated during this survey: DC00012567, DC00012739, DC00012742, DC00012783, DC00012913, DC00013064, DC00013242, DC00013314, DC00013355, DC00013376, DC00013502, DC00013557, DC00013614, DC00013623, DC00013625, DC00013626 and DC00013635. Federal and Local deficiencies were cited related to the investigation of: DC00012762, DC00012783, DC00012827, DC00013314, DC00013498, DC00013614, DC00013624, DC00013625 and DC00013626. The following is a directory of abbreviations and/or acronyms that may be utilized in the	L 000	**L 000**-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.	07/8/2025

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L 000	Continued From page 1 report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C- Discontinue Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass)	L 000		

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L 000	Continued From page 2 M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		
L 035	3207.10 Nursing Facilities Dated orders and dated progress notes in the resident's medical record shall be used to document medical supervision at the time of each visit and shall be signed and dated by the resident's physician or the resident's nurse	L 035	Tag: L 035- Drug Regimen Review (pgs. 3-4) Corrective Action for Identified Resident(s): The nurses responsible for the medication error were counseled and re-educated by the educator/designee on the Five (5) Rights of Medication Administration.	07/8/2025

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L 035	Continued From page 3 practitioner or physician assistant, with countersignature by the resident's physician. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 49 residents sampled, facility staff failed to ensure that Resident #53's medical supervision at the time of each visit included review of the documented consultant pharmacist's Medication Regimen Review (MRR) report. The findings included: Review of the facility's "Medication Regimen Review" policy dated 06/21/17 documented: - The pharmacist must report any irregularities to the attending physician, the facility's Medical Director, and Director of Nursing (DON), and these reports must be acted upon in a manner that meets the needs of the residents. - For non-urgent recommendations, the facility, and attending physician must address the recommendation(s) in a timely manner, no later than their next routine visit. Resident #53 was admitted to the facility on 10/29/24 with multiple diagnoses that included: Chronic Pain, Schizophrenia, Anxiety Disorder, and Anoxic Brain Injury. Review of the resident's medical record revealed the following: Physician's orders dated 10/29/24 that directed, "Lidocaine External Patch (topical pain reliever) 4% (Lidocaine), apply to left lower leg topically one time a day for leg pain; Olanzapine (Antipsychotic medication) oral tablet 2.5 MG (milligrams), give 2.5 mg via G (gastrostomy) -tube two times a day; Quetiapine Fumarate	L 035	Cont. Tag: L 035- Drug Regimen Review (pgs. 3-4) Identification of Other Residents: A med pass audit will be completed by unit managers by 6/30/25 to identify any potential issues of non-compliance. For any additional residents identified, immediate action will be taken to ensure staff education on medication administration protocols. Systemic Changes: At least 80% of licensed nurses will be provided a mandatory retraining on the Five (5) Rights of Medication Administration by the educator/designee, and Medication pass audits by the unit managers/designee will be increased to daily for 14 days. A competency validation process will be implemented by the educator/designee by 6/30/25 for at least 80% of licensed staff, including observation and competency validation. Monitoring of Corrective Actions: 1. The Unit Manager or designee will complete direct observation audits of 10 medication passes weekly for 4 weeks on all shifts and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. 2. In addition to facility medication pass audits, the Consultant Pharmacist will also conduct random medication pass audits monthly to validate compliance and track error rates. Any deficiencies noted will be corrected upon discovery. Trends and findings will be reported in QAPI to sustain a facility-wide error rate below 5%. Compliance and outcome data will be reviewed regularly to ensure continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt additional staff education or necessary system adjustments.	

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L 035	Continued From page 4 (Antipsychotic medication) oral tablet 150 MG, give 150 mg via G-Tube every 12 hours; and Acetaminophen (pain reliever) oral tablet, give 650 mg via G-Tube every 6 hours as needed (PRN) for Pain." A physician's order dated 11/20/24 that directed, "Oxycodone (narcotic pain reliever) HCl (hydrochloride) oral tablet 5 MG, give 1 tablet enterally every 4 hours as needed for Pain." It should be noted that this medication was discontinued (d/c) on 01/30/25. 11/21/24 at 5:50 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review (MRR) report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via G-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via G-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS (Centers for Medicare and Medicaid) with antipsychotic drug utilization, recommend review and clarify indication. - Lidocaine Patch 4%, apply to left lower leg topically one time a day for leg pain at 9:00 AM. Patch can be applied for up to 12 hours. There shall be a drug-free period of 12 hours. To avoid medication administration errors, clarify directions with prescriber to include "12 hours on and 12 hours off." Kindly update PointClickCare	L 035		

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L 035	Continued From page 5 (PCC/facility's electronic) and document lidocaine patch removal at 9:00 PM on the Medication Administration Record (MAR). Review of the MRR for November 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 12/19/24 at 1:41 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G (gastrostomy) - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). Review of the MRR for December 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 01/22/25 at 3:45 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use	L 035		

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L 035	Continued From page 6 of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. A physician's order dated 01/30/25 that directed, "Oxycodone HCl oral tablet 5 MG, give 1 tablet enterally every 6 hours as needed for Pain." Review of the MRR for January 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 02/16/2025 at 7:15 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for	L 035		

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L 035	Continued From page 7 antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. Review of the MRR for February 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 03/12/25 at 11:05 AM Care Conference Note: - [Resident #53] had a care conference held on 03/11/25 with the interdisciplinary team (IDT) team and niece to discuss the plan of care. - The plan of care was reviewed and will continue. A care plan focus area, reviewed on 03/11/25, documented, "[Resident #53] is at risk for adverse reaction r/t (related to) polypharmacy" with interventions that included, "Request physician to review and evaluate medications; review pharmacy consult recommendations, and follow up as indicated." Review of Resident #53's physician's orders showed that on 03/25/25 is when the resident's primary care doctor reviewed and acted upon the consultant pharmacist's recommendations and identified irregularities from November 2024, December 2024, January 2025 and February 2025. The evidence showed no documented evidence that from November 2024 through February 2025, four (4) months, the physician reviewed Resident #53's total program of care, to include medication management, as evidenced by the consultant pharmacist's identified irregularities and recommendations not being acted upon.	L 035		

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L 035	Continued From page 8 During a face-to-face interview on 04/28/25 at 2:55 PM, Employee #2 (DON) was asked why Resident #53's medication regimen reviews were not reviewed or acted upon from November 2024 - February 2025. Employee #2 stated, "[Resident #53's] primary doctor was also the medical director, who left abruptly, without notice on 01/27/25. Her residents were then picked up by [Physician's name], who also became the Medical Director. Once reviewed and acted upon, the forms are given back to the clinical team to file. I am not sure why the doctors did not review the MRRs for [Resident #53] for those months."	L 035		
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	L 051	Tag: L 051- Develop/Implement Comprehensive Care Plan (pgs. 9-10) Corrective Action for Identified Resident(s): The care plan for resident # 38 was updated on 6/13/25 to address the resident's mechanically altered diet. Resident #65 orthotic foot brace was discontinued on 5/21/2025. The care plan for resident #68 was updated on 6/12/2025 to reflect the resident's preference for interpreter services, ensuring communication services are met. The care plan for resident #84 was updated on 5/2/2025 for the management of an indwelling urinary catheter, including monitoring and care interventions. The central line IV for resident #91 was discontinued on 4/13/25.	07/8/2025

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L 051	Continued From page 9 (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, for four (4) of 49 sampled residents, the charge nurse failed to review residents' plans of care for apropppriate goals and approaches to address: (1) Resident #38's use of a mechanically altered diet 2) Resident #65's use of an orthotic foot brace for immobilization ; (3). Resident #68's preference to use an interpreter when communicating with a doctor or health care staff; (4) Resident #84's use of an indwelling urinary catheter care (5) Resident #91's use of a left upper arm central intravenous (IV) line. . (Residents #38, #65, # 68, and #84) The findings included: 1. Resident #38 was readmitted to the facility on 09/11/24 with multiple medical diagnoses that included Dysphagia following Cerebral Infarction, Hemiplegia, Oropharyngeal Disease. A physician order dated 02/12/24 instructed, "Pleasure Feed Diet-Soft and Bite-Sized Texture (mechanically altered diet)...Assist feed, small bites/sips, slow rate intake, alternating consistencies." Review of resident's care plans lacked documented evidence that the charge nurse reviewed the resident's plans of care for apropppriate goals and approaches to address the resident's mechanically altered diet. During an observation on 04/22/25 at approximately 11:30 AM, Resident #38 was awake and sitting in bed at a 90- degree with a	L 051	Cont. Tag: L 051- Develop/Implement Comprehensive Care Plan (pgs. 9-10) Identification of Other Residents: The unit managers/designee conducted a comprehensive audit of residents with specialized diets, indwelling catheters, IV lines, language barriers, and the use of orthotics to identify similar deficiencies by 6/30/25. Any additional residents identified during the audit process had their care plans reviewed and revised by the unit manager/designee. Systemic Changes: 1. All IDT members were re-educated on the care planning process on 6/30/2025, including timely updates following changes in condition or resident preferences. 2. The care plan review process was reviewed by the DON to ensure individualized care plans for residents with similar deficiencies. The MDS Coordinator now reviews relevant areas for verification during the care plan process. Monitoring of Corrective Actions: The MDS Coordinator or designee will audit 10 charts of newly initiated or revised care plans weekly for 4 weeks and monthly for 3 months to ensure individualization and completeness. Any deficiencies noted will be corrected upon discovery. Results will be presented at QAPI meetings for trend analysis and follow-up. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustments.	7/8/2025

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L 051	Continued From page 10 lunch tray in front of him on a bedside table. Additionally, Employee # 11 (assigned CNA) was standing by the side of the resident's bed preparing to feed the resident. During a face-to-face interview on 04/22/25 at approximately 11:30 AM, Employee #10 (RN/Nursing Supervisor) stated that she did not see that a care plan with goals and approaches to address the resident's mechanically altered diet. 2. Resident #65 was admitted to the facility on 01/22/24 with diagnoses that included: Traumatic Brain Injury with Loss of Consciousness of Unspecified Duration, Chronic Respiratory Failure; Traumatic Spinal Cord Dysfunction;) Quadriplegia, Contracture of the Knee (Unspecified), Contracture of the Foot (Unspecified); Neuromuscular Dysfunction Of Bladder; Urinary Tract Infection; Encounter for Attention to Gastrostomy; Encounter for Attention to Tracheostomy, Anxiety Disorder and Depression. A review of Resident #48's medical record revealed: An admission MDS (Minimal Data Set) assessment dated 01/24/24 that documented the Resident had a Brief Interview for mental Status (BIMS) summary score of, "14" indicating that the Resident had intact cognition. In addition, the resident was coded for: impairment status on both sides to the upper and lower extremities; dependent status on for all (activities of daily living skills (ADLs) including turning and repositioning, having a fall in the last month prior to admission, having recent spinal surgery, having a gastrostomy tube, having a tracheostomy, and receiving speech and	L 051		

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L 051	Continued From page 11 occupational therapies. An SBAR dated 01/02/25 that documented: "Situation: Rt (Right) plantar foot swollen. Order for X-Ray of Rt plantar foot; Assessment (Registered Nurse/RN) or Appearance (Licensed Practical Nurse/LPN): Swollen Rt plantar foot; Request/Nursing Notes: Order given by NP (Nurse Practitioner) on duty for X-ray of the right plantar foot to rule out fracture. Resident aware, RP/Friend [Name of resident representative] notified ..." An X ray Report dated 01/02/25 that documented: "Clinical History: [Resident] presents for fracture. Technique: 3 views of the right foot Comparison: None. Findings: Diffuse soft tissue swelling about the right foot. Diffuse osteopenia. Cannot exclude an acute fracture on this ..." A General Progress Note dated 01/03/25 at 6:57 PM that documented: "Resident lab result received findings stated " 'Diffuse osteopenia. Cannot exclude an acute fracture on this limited osteopenic study. Suggestion of a fracture of the distal fibula. No dislocation.' [Name of Medical Director] was called by the 4th floor unit manager ... She stated 'We need to send him to orthopedics. I don't think that is acute. [An] elective consultation arrangement will be made. I will contact [Rehab Director's Name] to put a boot on it....." A care plan initiated on 01/03/25 that documented:": [Name of Resident #68] has Diffuse osteopenia. Cannot exclude an acute fracture on this limited osteopenic study ....No dislocation." Goal: Resident will verbalized reduction of pain by the next review date. Interventions initiated 01/04/25: Elective consultation arrangement will be made by MD ;	L 051		

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L 051	Continued From page 12 Log roll resident during transfer and observe foot precaution; MD will follow up with rehab for boot ..." A revised care plan dated 01/03/25 that documented: "[[Name of Resident #68] has diffuse osteopenia and at risk for fracture r/t x-tray of the right foot dated 01/03/2025 Date Intervention included: "...Orthopedic consult; Provide with pillows, etc. to help maintain comfortable position; PT (Physical Therapy) evaluation and treatment as ordered.". 01/06/25 physician's order that directed: "PT (Physical Therapy) Consult and prn (as needed), right foot boot for immobilization, distal fibula fracture. A Physical Therapy Encounter Note dated 01/09/25 that documented: " ... Pt was seen in room and was given foot brace to wear to immobilize ankle. 01/09/25 Physical Therapy Encounter Note: " ... Pt (Patient) was seen in room and was given foot brace to wear to immobilize ankle. Pt tolerated foot brace well and NP (Nurse Practitioner) also said it was good for patient ..." A further review of Resident# 65's comprehensive care plan showed no documented evidence that facility developed or implemented a care plan with a focus, goals or interventions for the resident's right foot boot for immobilization. During a face-to-face interview on Employee #21, Director of Rehab stated that the Resident was given the immobilization boot on 01/09/25 from phyiscal therapy, and a care plan for the boot should have been implemented then. During a face-to-face interview on 05/01/25 at	L 051		

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L 051	Continued From page 13 1:25 PM Employee #2 Director of Nursing (DON) stated that the Unit supervisors, unit managers, and the DON and all members of the disciplinary team were responsible for implementing the care plans. She further commented that since the fourth floor had currently had no unit Manager, implementing and updating resident care plans was primarily her responsibility. The Employee then acknowledged that a care plan for Resident # 65's right foot immobilization boot should have been implemented. 3. Resident #68 was admitted to the facility on 03/25/24 with diagnoses that included: History of Falling; Acute Respiratory Failure; Displaced Interrogate Fracture of Right Femur, Trial Fibrillation; Chronic Hepatitis, Orthostatic Hypotension, Restlessness and Agitation. A review of Resident #68's medical record revealed: An admission annual MDS (Minimal Data Set) assessment dated MDS 03-11-24 which documented that the Resident had a Brief Interview for mental Status (BIMS) summary score of, "05" indicating that the Resident had severely impaired cognition. In addition the assessment documented that Resident's preferred language was Spanish and the Resident needed and wanted an interpreter to communicate with a doctor or health care staff. An annual MDS (Minimal Data Set) assessment dated MDS 02-28-25 which documented that the Resident had a Brief Interview for mental Status (BIMS) summary score of, "13" indicating that the Resident had intact cognition. In addition, the assessment documented that Resident's preferred language was Spanish and the Resident needed and wanted an interpreter to	L 051		

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L 051	Continued From page 14 communicate with a doctor or health care staff. During an initial tour of the 4th floor unit on 04/13/25 at 8:09 AM, a face-to-face interview was conducted with Resident #68 and a Spanish speaking interpreter (via the facility's language interpreter phone line service), the Resident stated he spoke very little English and he preferred to speak Spanish. The resident added that he could communicate with the staff, but sometimes he didn't understand what the staff and he was not sure if they could understand him. When asked if facility staff offered use of via Spanish interpreter via the language line he said, "No, not so much. My brother speaks English, so if something happens I let my brother know. He talks to the facility staff." During an initial tour of the 4th floor unit on 04/13/25 at 8:25 AM, a face-to-face interview was conducted with Employee #46 /Licensed Practical Nurse assigned to Resident #68. When asked if the Employee used the language line to communicate with the Resident, she stated, " No. The Resident is Spanish, but he understands and speaks English." A review of Resident #68's comprehensive care plan lacked documented evidence that facility staff implemented a care plan for the resident's preference to use a Spanish speaking interpreter when communicating with a doctor or health care staff. During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 stated since the fourth floor had currently had no unit Manager, she was primarily responsible for implementing and updating resident care plans. The Employee then stated and acknowledged that although Resident	L 051		

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L 051	Continued From page 15 #68 understands and speaks some English, a care plan for the Resident's preference to use an interpreter when communicating with a doctor or health care staff should have been developed, implemented and included in the resident's person-centered comprehensive care plan. 4. Resident #84 was admitted to the facility with the following diagnoses: Metabolic Encephalon; Quadriplegia;Traumatic Spinal Cord Dysfunction; Chronic Respiratory Failure; Dependence On Respirator [Ventilator] Status; Encounter for Attention to Tracheostomy; Dysphasia; Encounter for Attention to Gastrostomy, Anxiety Disorder and Depression. A Quarterly Minimum Data Set (MDS) assessment dated 01/15/25 documented that Resident #84 had a Brief Interview for Mental Status (BIMS) of, "15" indicating that the Resident had intact cognition. In addition, the resident was coded as having impairment s on both sides for the upper and lower extremities, limited range of motion; was dependent on staff for all ADLs (activities of daily living) including, had an indwelling urinary catheter, had a urinary tract infection within past 30 days of the assessment and had received antibiotic treatment. An SBAR Communication Form dated 01/02/25 that documented: Situation: Resident was noted with blood in Foley bag ...Request/Nursing Notes: Patient was noted with blood in Foley bag, he denied pain or discomfort on the lower abdomen, abdomen soft, non-distended, temp of 98.0. MD (Medical Director) notified, after assessment, new order for USA (urinalysis) AC/S (culture and specimen). RP (Representative) at the bedside made aware	L 051		

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L 051	Continued From page 16 A physician's order dated 01/04/25 that directed: " Bactrim DS Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet via PEG-Tube (percutaneous endoscopic gastrostomy) every 12 hours for UTI (urinary tract infection)for 7 Days." A physician's order dated 01/07/25 that directed: " Change 18Fr Foley catheter, tubing and drainage bag monthly. every night shift starting on the 7th and ending on the 7th every month." A physician's order dated 02/10/25 that directed: " Foley catheter care q shift and record out put. every shift." An SBAR Communication Form dated 02/11/25 that documented: Situation: Sediments in urine ...Request/Nursing Notes: Sediment noted in the urine bag, resident denied pain or abdominal discomfort. NP notified, order for Urinalysis Complete, urine culture. A review of Resident #84's comprehensive care plan lacked documented evidence that facility staff developed and implemented a comprehensive patient centered care planned that included a focus, goal, and interventions for the Resident's indwelling urinary catheter. During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 stated since the fourth floor had currently had no unit Manager, she was primarily responsible for implementing and updating resident care plans. The Employee then acknowledged that a care plan for the Resident #84's indwelling urinary catheter care should have been developed, implemented, and included in the resident's person-centered comprehensive care plan.	L 051		

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L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as 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	L 052	~~Tag: L 052- Treatment/Prevention of Pressure~~ Ulcers (pgs. 18-19) Corrective Action for Identified Resident(s): Resident #47 was immediately assessed by the wound care team on 6/13/2025, and a comprehensive treatment plan was initiated, including appropriate wound care interventions and consultations with a wound care specialist. The resident's care plan was updated on 6/13/25 by the wound nurse to reflect the current status and treatment of the pressure injury, with documentation of the wound's progress. Resident #38 received the prescribed water flushes via PEG tube immediately on 4/18/2025. The attending physician was notified of the oversight on 6/16/2025. A dehydration risk screen was completed on 6/11/25. The resident's care plan was reviewed and updated on 6/16/25 with the frequency of water flushes. Identification for other Residents: 1. A facility-wide skin sweep and assessment was completed for all residents by the wound team on 6/9/25 to identify any other potential pressure injuries. No additional pressure injuries were noted; other identified skin issues were immediately addressed. 2. Residents at risk for pressure ulcers will be identified and their care plans individualized to include preventive measures. Any deficiencies noted will be corrected upon discovery. Systemic Changes: 1. At least 80% of licensed nurses and nursing assistants will receive re-education by the educator/designee on wound care protocols, including risk identification and treatment strategies for pressure injuries—by 6/30/2025. 2. The Wound Director has implemented routine skin checks by licensed staff on shower and bed bath days. 3. Nursing assistants are required to notify a nurse to perform a head-to-toe skin assessment following each shower or bed bath.	07/8/2025

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L 052	Continued From page 18 independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record reviews and staff interviews, for two (2) of 49 sampled residents, the facility staff failed to give sufficient nursing time to ensure: (1a)Resident #38 received water flushes [fluids] via Percutaneous Endoscopic Gastrostomy (PEG) as perscribed; (1b) Resident #38 recieved a diet as perscibed. Subsequently, the resident was served roast beef that was not mechanically altered to bite size as prescribed (2) Resident # 47 recieved proper care to minimize pressure ulcers. Subsequently, the resident who was identified by staff as at risk for developing pressure ulcers developed a pressure injuries/ulcer of the left lateral foot that was first identified at an advanced stage (Stage 3). Residents #38, and #47. The findings included: Resident #38 was admitted on 07/07/22 with multiple medical diagnoses including Dysphagia following Cerebral Infarction, Oropharyngeal Disease, Gastrostomy Tube, Gastro-Espohgeal Reflux, and Loss of Teeth. 1a. A care plan with a review date of 09/13/24 documented in part, "Focus - [Reside#38] requires tube feeding related to Dysphagia...Interventions -The resident is dependent with [PEG] tube feeding and water flushes ..."	L 052	Cont. Tag: L 052- Treatment/Prevention of Pressure Ulcers (pgs. 18-19) 4. CNA assignments will be updated to include reminders for visual skin checks during activities of daily living (ADLs). 5. At least 80% of licensed nursing staff have been re-educated by the educator/designee on PEG tube care, including proper pump use, water flush techniques, and required documentation. 6. Licensed staff were provided a review of the facility's enteral nutrition protocol during education. A new procedure requires nursing staff to document PEG tube flushes in the electronic health record immediately after administration. 7. The dietitian and nurse managers now jointly review tube feeding compliance during weekly clinical meetings. Monitoring of Corrective Actions: 1. The Wound Nurse or designee will audit 20 charts of at-risk residents for developing pressure ulcers. Audits will be completed weekly for 4 weeks and then monthly for 3 months to ensure compliance with the skin check protocol. Any deficiencies noted will be corrected upon discovery. 2. The Director of Nursing or designee will audit 20 charts of residents receiving tube feedings weekly for 4 weeks and monthly for 3 months to ensure compliance with water flushes and care protocols. Any deficiencies noted will be corrected upon discovery. Compliance and Outcomes will be discussed during QAPI meetings for continued oversight. Any trends identified will trigger further education or systems adjustment.	7/8/2025

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L 052	Continued From page 19 A physician order dated 02/12/25 instructed, "hydration water flushes 300 milliliters every four (4) hours via [PEG] tube." During an observation on 04/18/25 at approximately 11:00 AM, Resident #38 was lying in bed, alert and oriented to name. The resident was receiving enteral water flush hydration via gastrostomy tube. The resident's feeding pump for water flushes was set at 300 milliliters every six (6) hours. During a face-to-face interview with on 4/18/25 at approximately 11:00 am, Employee #14 (assigned LPN) stated that the feeding pump's water flush frequency setting of every six hours was incorrect. The resident has a order for water flushes every (4) hours. The employee immediateley changes the setting to every four (4) hours. When asked, did he check the tube feeding setting when he started his shift, the employee stated, "No." 1b. A physician's order dated 02/12/25 instructed "Pleasure diet -soft and bite sized texture ...upright 90-degree positioning, assist feed, small bites/sips, slow rate ..." Please note: This is a pleasure diet the resident received gastrostomy tube feeding daily, per physician order. A speech therapy evaluation and plan of treatment dated 03/31/25 - 04/29/25 documented in part, "Treatment of swallowing dysfunction ...evaluation of oral and pharyngeal swallowing function ... Goal-Patient will consume soft/bite sized solids ...Risk Factors-due to physical impairment and associated functional deficits,	L 052		

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L 052	Continued From page 20 without skilled therapeutic intervention, the patient is at risk for aspiration ..." During an observation on 04/22/25 at approximately 1:30 PM, Resident #38 was observed awake, sitting in bed with head of bed elevated at a 90-degree angle. A bedside table with a lunch tray was positioned directly in front of the resident. The lunch tray consisted of a small bowl of roast beef chunks in gravy and one cup of juice. At the time of the observation, Employee # 11 (assigned CNA) was standing to the left of the resident's bed stating that she was getting ready to feed the resident. When asked, was the roast beef the appropriate diet for the resident, the employee failed to answer. The surveyor asked the employee not to feed the resident until Employee #15 (Speech Pathologist) could view the tray. Also noted during the observation was Feeding Protocol that was posted on the left wall of the resident's bed. The Feeding Proctol documented in part, "Soft and bite-sized pleasure diet ...maintain upright posture (90-degree angle) during po (by mouth) intake ..." During a face-to-face interview conducted outside in the resident's room 04/22/25 at approximately 1:35 PM, Employee #15 (Speech Pathologist) viewed the lunch tray and stated that the roast beef appeared to be larger than bite sized. The employee then stated, "This is unsafe for the resident. Bite sized is no larger than 1.5 centimeters. I will go down and talk to dietary." During a face-to-face interview on 04/22/25 at approximately 1:40 PM, Employee #17 (Dietician) stated that she was not sure if the roast beef was bite sized. She would talk with dietary staff to find out.	L 052		

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L 052	Continued From page 21 During a face-to-face interview on 04/23/25 at approximately 9 AM, Employee #37 (Director of Food and Nutrition) stated that her staff made an error with the resident's lunch tray on 04/22/25. The employee then said, "They sent the resident a regular diet instead of bite sized." 2.Resident #47 was admitted to the facility on 10/26/22 with multiple diagnoses including Quadriplegia, Encephalopathy, Chronic Respiratory Failure (Hypoxia) and Muscle Weakness. A policy titled, "Prevention of Pressure Ulcers/Injuries" with a revision date of 05/24/24 instructed staff to, "Inspect the skin on a daily basis when performing or assisting with personal care or ADLs (activities of daily living); Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) ...Moisturize dry skin daily; and Reposition resident as indicated on the care plan ..." A physician order dated 11/06/24 instructed, "Aquaphor External Ointment (Emollient) apply to bilateral lower extremities topically two times a day for wound care. Off-load bilateral heel with off-loading device every shift for pressure redistribution ...Turn and reposition every two hours using wedges or pillows for pressure redistribution every shift." A plan of care with a review date of 11/07/24 documented in part, " Focus- [Resident #47] is activity of daily living dependent secondary to Quadriplegia with incontinence of bladder and	L 052		

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L 052	Continued From page 22 bowel with inability to communicate needs ...Interventions - assess, record, report and treat for any abnormality to skin during incontinent care, dependent on 2 staff to provide bath/shower and turning and repositioning every 2 hours and as necessary ...totally dependent on 1 staff for personal hygiene ..." A physician order dated 11/08/24 instructed, "Perform skin assessments on shower days twice a week and notify MD of any new changes every Tuesday and Friday. A quarterly Braden Scale for Predicting Pressure Score Risk dated 11/21/24 documented that the resident had a score of "15" indicating that the resident was at risk for developing pressure ulcers. Progress notes dated 11/22/24 to 01/07/25, lacked documented evidence of an alteration in the skin integrity of Resident #47's left foot. Treatment Administration Records dated 11/22/24 to 01/07/25, licensed nursing staff documented that the following tasks were performed for the resident: Skin assessments (head-to-toe) conducted by licensed staff twice a week on shower days; Aquaphor ointment was applied to bilateral lower extremities twice a day; Turned and repositioned daily, every two hours; Bilateral heels were off loaded (elevated) with off-loading devices (wedges/pillows) daily, every shift. However, the facility staff failed to identify the resident's left foot pressure ulcer until 01/08/25 when it was an advanced stage (Stage 3). A Situation, Background, Assessment, Request (SBAR) form dated 01/08/25 at 7:29 PM signed by Employee #14 (LPN) documented in part,	L 052		

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L 052	Continued From page 23 "Discovery of wound on left lateral aspect of the left foot started on 01/08/25 ... resident properly repositioned and turned every 2 hours for purpose of proper weight distribution and prevention of further skin injury. Nurse Practitioner notified of wound and wound consult placed an order obtained for treatment of wound ..." A wound care nurse practitioner progress note dated 01/09/25 at 7:23 PM documented in part, " Reason for visit: new skin and wound consult ...Patient with new stage 3 pressure injury to the left lateral distal foot ... Lower Extremity Exam ...Texture: dry, flaky, thickened, Perfusion: diminished pedal pulses, left foot cool to touch, Sensation: Bilateral lower extremity insensate, Associated Findings: generalized dryness ... Wound Status: Odor Post Cleansing: None, Size: 1 cm (centimeters) x 0.8 cm x 0.2 cm. Calculated area is 0.8 sq (square) cm, Wound Base: 20% epithelial , 70% granulation , 10% slough , 0% eschar, Wound Edges: Attached Periwound: Fragile, Callous, Exposed Tissues: Subcutaneous, Exudate: Moderate amount of Serosanguineous ...Treatment- cleanse wound with wound cleanser, apply Iodosorb (topical antiseptic ointment) to base of wound, secure with boarder gauze, change daily ..." An observation with the wound nurse on 04/22/25 at approximately 12:30 PM showed the resident lying in bed, awake, non-verbal, and well groomed. The resident had a dressing to the left foot. The dressing was dry and intact. When the wound nurse practitioner removed the dressing, the wound had no smell, was approximately 1 inch in width and no depth, red tissue in center with pink surrounding tissue.	L 052		

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L 052	Continued From page 24 During a face-to-face interview on 04/22/25 at approximately 12:30 PM, Employee #35 (Nurse Practitioner - Wound Specialist) stated that staff informed him on 01/08/25 that the resident had a new wound on his left foot. On 01/09/25, he assessed the resident and determined that he had a Stage 3 pressure wound to the left lateral foot. Also, Employee #35 said that he requested a longer bed for the resident because the resident's left foot was pressing against the bed's footboard which likely contributed to pressure at the site of the pressure injury. As a result, Resident #47 subsequently was issued a new bed with an extended footboard. During a face-to-face interview on 04/30/25 at approximately 3 PM, Employee #14 (assigned LPN) stated that he should have documented the characteristics of the resident's wound (size, depth, color, odor) on the SBAR dated 01/08/25. Additionally, the employee said that he conducts head-to-toe-assessments skin assessments twice a week and as needed. And he ensures that the resident is turned and reposition every-two-hours daily and heels are always elevated off the mattress to prevent pressure. During a face-to-face interview on 04/30/25 at approximately 3:30 PM, Employee #10 (RN/Nurse Supervisor) reviewed the resident's medical record and said that she did not see documentation of a skin integrity issue with the resident's left foot before 01/08/25. During a face-to-face interview on 05/01/25 around 3:30 PM, Employee #36 (Central Supply Technician) indicated that he had received an electronic work order for a longer bed for Resident #47. According to the employee, he did not keep a copy of the work order and could not	L 052		

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L 052	Continued From page 25 recall the exact date when he received it. However, he remembered that he provided the resident with a bed that extended at the foot portion on 02/18/25. Please cross reference 483.25 Quality of Care (F686)	L 052	Tag: L 056- Minimum Staffing (pgs. 26-27) Corrective Action for Identified Deficiency: Upon identification, the Administrator and Director of Nursing conducted an immediate staffing review and adjusted schedules to ensure compliance on 5/5/2025. Agency staff were brought in to cover open shifts, and part-time employees were offered additional hours. The staffing schedule was reviewed, and state-required postings were updated by 7/8/25. Identification of Other Areas or Residents: 100% of staffing records for the past 30 days were audited against state minimum staffing requirements by the administrator to identify any additional days of noncompliance. This was completed by 6/30/2025. The audit included shift logs and assignment sheets. If areas of non-compliance is identified during the audit, they were immediately addressed. Systemic Changes: 1. The scheduling coordinator, Administrator, and DON were re-educated by the Regional Director of Operations on 6/30/25 on daily staffing minimums and the requirement to comply with the state regulation (22B DCMR sect. 3211.5). 2. A staffing matrix was developed and implemented to guide shift assignments based on census and acuity by 7/8/25. 3. The facility has initiated a proactive recruitment campaign. 4. The Administrator and staffing coordinator now conduct a daily staffing huddle to confirm compliance with the minimum staffing requirement.	07/8/2025
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and a staff interview, the facility failed to ensure that a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day for seven (7) of 35 sampled days reviewed. Also, the facility failed to provide at least six thenths (0.6) hours by an advanced practie registered nurse or registered nurse for one (1) of 35 sampled days reviewed. The findings included: A review of the facility's daily staffing sheets revealed the following: On 10/19/24 the facility's resident census was	L 056		

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L 056	Continued From page 26 110. In addition, residents received 3.9 hours of direct nursing care. On 11/24/24 the facility's resident census was 105. In addition, residents received 3.8 hours of direct nursing care. On 12/21/24 the facility's resident census was 110. In addition, residents received 3.3 hours of direct nursing care with 0.50 of those hours being provided by a registered nurse. On 12/22/24 the facility's resident census was 110. In addition, residents received 3.6 hours of direct nursing care. On 12/29/24 the facility's resident census was 109. In addition, residents received 4.0 hours of direct nursing care. On 04/18/25 the facility's resident census was 106. In addition, residents received 3.9 hours of direct nursing care. On 04/26/25 the facility's resident census was 104. In addition, residents received 4.0 hours of direct nursing care. During a face-to-face interview on 05/05/25 at approximately 10:00 AM, Employee #22 (Staffing Coordinator) stated that they were short of staff on the previously mentioned days because they were hiring in the process of hiring additional staff. Additionally, the employee said that she was not aware of the staffing requirements.	L 056	Cont. Tag: L 056- Minimum Staffing (pgs. 26-27) Monitoring of Corrective Actions: The Administrator or designee will review staffing levels daily for 14 days, then weekly for 4 weeks, and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. Compliance and Outcomes will be discussed at QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment	
L 070	3214.4 Nursing Facilities A facility shall designate an In-Service Education	L 070	Tag: L 070- Training Resident Rights (pgs. 27-28) Corrective Action for Identified Deficiency: Review by the educator/designee of personnel records showed incomplete annual training modules for several staff, including orientation topics, resident rights, and general care expectations. Staff identified were immediately removed from the assignment until training was completed. All missing training was be completed by 6/30/2025. No adverse resident outcomes were linked to the training lapses.	07/8/2025

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L 070	Continued From page 27 Director who shall maintain records of training and orientation activities which include the agenda, instructions, and participants. Records of each in-service education program shall be kept on file and available for inspection. This Statute is not met as evidenced by: Based on record reviews and staff interviews, facility staff failed to designate an In-Service Educator Director who maintained records of training and orientation activities that included the agenda, instructions and participants for in-service education provided to nursing personnel. The findings included: A review of the Facility's Assessment updated 12/03/24, that documented: " ...Section 3.4 Staff Training/Education and Competencies. We only hire individuals that are eligible to work in The District of Columbia, currently using temporary nursing assistant(s). Department and job specific competencies are completed during orientation and reviewed annually. Competencies follow a pattern of requirements for certification and licensure renewal and trends of events within the facility and industry as a whole ...List of competencies include- tracheostomy, ventilator, Enteral Tube feeding, ostomy, IVs (intravenous), TPN, (total parenteral nutrition) vital signs, weight taking, height measuring, oxygen, suctioning, systems assessment, turning and repositioning, SBAR (Situation, Background, Assessment, Request) Communication Forms, Care plan, change in condition communications, computer documentation and changes in condition and reporting, complaint management, drains, referrals, appointment making, assistance with ADLs (activities of daily living skills), wound care, IDT (interdisciplinary team) assessments and	L 070	Cont. Tag: L 070- Training Resident Rights (pgs. 27-28) Identification of Other Staff or Residents: 1. 100% of employee training records was audited by the educator/designee by 6/30/2025 to verify completion of required general training modules. 2. Staff with missing or outdated training were removed from the schedule until fully compliant. Systemic Changes: 1. The Regional Director of Operations revised the facility's policy on staff education regarding resident rights and responsibilities to include mandatory annual training sessions. The leadership team, including the Administrator, Director of Nursing, Educator, and department heads were trained on the staff education policy by the Regional Director of Operations by 7/8/25. 2. Education developed a structured training program on resident rights and facility responsibilities, to be completed by all new hires and annually by existing staff. 3. Education implemented a new protocol for documenting staff training sessions, including attendance records and training materials, to ensure accountability and traceability. Monitoring of Corrective Actions: The Educator/designee will audit 100% of employee training records monthly for 3 months, then 25% monthly for an additional 3 months. Any deficiencies noted will be corrected upon discovery. Compliance and Outcomes will be reported and discussed at QAPI meetings for continued oversight. Any trends identified will prompt further education or systems adjustment.	

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L 070	Continued From page 28 isolation." A review of the facility's policy entitled, "Resident Rights," (revised 05/24/24) documented " ...Orientation and in-service training programs are conducted quarterly to assist our employees in understanding our residents' rights. On 05/05/25, the facility's education and training records for Residents' Rights were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. Inside of the binder was a table of education topics with the heading, "2024 SNF (Shared Nursing Facility) Skills Fair Training. In the first column of the table was a list of several training topics including Resident Rights and Facility Responsibilities. In the column next to Residents Rights were the comments, "Review and packet and HealthStream. Attached to the Skills Fair Training document was a September 19-20-2024, 24-page sign-in sheet with the signatures of some staff who attended the skills fair training, however there was no documented evidence that showed what the HealthStream education/training for Residents Rights consisted of and there was no documented evidence to show that the educator provided a review and packet for Resident Rights to facility staff as part of their education and training. In addition, there was no documented evidence that staff who were not present for the September 19-20, 2024, skills fair, received the training. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records. During a face-to-face interview on 05/05/25 at	L 070		

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L 070	Continued From page 29 9:15 AM, Employee #48/Regional Director of Operation stated, "All staff receive education and training on Residents Rights that they during orientation before they are assigned to the floor and as part of the staff skills fair training annually". Employee #48 then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated that all she could find was the list of training topics for the 2024 SNF Specific Skills Fair Training and the sign-in sheets. She commented further that she could not substantiate what specific information the staff educator provided for review or in the education packet for Resident Rights. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1/Administrator stated, "The staff is not getting the education to the extent needed; the Director of Nursing and myself (Administrator) provide some of the education PRN (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it."	L 070	Tag: L 099- Food under sanitary condition (pgs. 30-32) Corrective Action for Identified Deficiencies: 1. Upon identification, the kitchen was inspected by the Dietary Manager and Maintenance Director on 4/13/2025. Immediate actions were taken the same day, including discarding expired and unlabeled food and replacing the eyewash solution. 2. Immediate corrections were made on 4/13/25: unlabeled and expired food was discarded, the curtain was replaced on 4/21/25, fans were cleaned on 4/14/25, ceiling light covers were cleaned 4/20/25, the eyewash solution was replaced on 4/13/25, and missing ceiling tiles were reported and repaired on 4/14/2025. 3. Non-functioning steamers and food warmers were removed from the kitchen on 6/11/2025. The garbage disposal was repaired 4/13/25.	07/8/2025
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:	L 099		

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L 099	Continued From page 30 Based on observations and interview, during a tour of the kitchen on April 13, 2025, at approximately 6:30 AM, facility staff failed to store and distribute food under sanitary condition as evidenced by one (1) of one (1) open bag of shredded carrots that was stored in the walk-in freezer undated, two (2) of five (5) torn air/strip curtains in one (1) of one (1) walk-in refrigerator/freezer unit, six (6) of six (6) ceiling lights above the three-compartment sink that were soiled with dust, one (1) of two (2) open eyewash solution bottle that was stored by the tray line for use, one (1) of two (2) garbage disposals that was inoperative , two (2) of two steamers with an 'out of service since May 8, 2023' sign, one (1) of two food warmers that has been inoperative since June 1, 2023. In the dry storage room, one (1) of five (5) 33.8 fluid ounces of Twocal, calorie & protein nutritional drink expired as of April 1, 2025, three (3) of 18 celling lights were missing a light bulb tube guard, and a ceiling tile that had been removed, needed to be replaced. The findings included: 1. An open bag of shredded carrots was stored in one (1) of one (1) refrigerator/freezer unit with no label to indicate when it was opened. 2. Two (2) of five (5) air/strip curtains in one (1) of one (1) walk-in refrigerator/freezer unit, were torn. 3. Six (6) of six (6) ceiling light covers above the three-compartment sink were soiled with dust. 4. One (1) of two (2) bottles of eyewash solution stored for use near the tray line, was stored open, with a	L 099	Cont. Tag: L 099- Food under sanitary condition (pgs. 30-32) Identification of Other Areas: 1. An audit of all food storage areas to identify any other undated or expired items was completed on 4/13/25. All identified items were discarded. 2. An inspection of all equipment and lighting in the kitchen and storage areas was completed by the maintenance manager on 4/14/2025 to ensure functionality and cleanliness. 3. Additional light fixtures will be replaced by 6/30/2025. Systemic Changes: 1. All dietary staff received re-education on proper food labeling, storage, updated policy, and cleaning duties by the dietary manager by 7/8/25. 2. Plant Operations was directed to coordinate with Dietary for the routine cleaning of high surfaces and fans. 3. Equipment maintenance logs are now reviewed monthly, with any faulty equipment reported through the work order system. 4. The food storage policy was reviewed by the dietary manager to mandate labeling of all opened items and regular checks for expired products. 5. Maintenance protocols were revised by the maintenance and dietary managers to require monthly equipment inspections and prompt repair or replacement of any non-functional items. 6. The dietary manager established a routine inspection process was implemented for all kitchen and storage areas to ensure ongoing compliance with sanitation standards.	

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L 099	Continued From page 31 broken sterility seal, and needed to be discarded. 5. One (1) of two (2) garbage disposal units was inoperative. 6. Two (2) of two (2) steamers have been out of service since May 8, 2023. 7. One (1) of two (2) food warmers has been out of service since June 1, 2023. 8. In the dry storage room, one (1) of five (5) 33.8 fluid ounces of Twocal, calorie & protein nutritional drink expired as of April 1, 2025, three (3) of 18 ceiling lights did not have a light bulb tube guard, and a ceiling tile that had been removed, needed to be replaced. Employee #37 acknowledged the findings during a face-to-face interview on April 17, 2025, at approximately 3:00 PM.	L 099	Cont. Tag: L 099- Food under sanitary condition (pgs. 30-32) Monitoring of Corrective Actions The Dietary Manager or designee will complete weekly sanitation and equipment audits of 100% of kitchen zones for weekly for 4 weeks and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. Compliance will be discussed during QAPI. Outcomes will be reported at QAPI meetings for continued oversight. Any trends identified will trigger further education or systems adjustment	
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations, record reviews and staff interviews, facility staff failed to ensure that each expired medication was removed from storage, as evidenced by storing: three (3) opened and undated vials of insulin for three residents in the medication refrigerator, two, opened, expired insulin vials for two (2) residents in the medication refrigerator, and by failing to remove one Resident's insulin pen from the medication	L 161	Tag: L 161- Label/Store Drugs and Biologicals (pgs. 32-33) Corrective Action for Identified Resident(s): The identified insulin products for Residents #9, #64, #77, #209, and #259 were immediately removed and discarded according to facility policy by 6/30/25. Each resident's medication administration record was reviewed by the unit manager/designee by 7/8/25 to confirm no missed or duplicated doses. The nursing staff responsible was re-educated by the educator/designee on proper labeling, dating, and removal procedures for medications by 7/8/25.	07/8/2025

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L 161	Continued From page 32 refrigerator after the Resident was discharged from the facility. Residents #9, # 64, #77, #209, and #259. The findings included: 1.On 04/23/25 at 12:03 PM, during an observation of the 5th Floor Medication Storage Room, one opened, expired vial of Humalog Mix 75/25 insulin for Resident #9 was observed in the medication room refrigerator. A handwritten date was observed in the box that the vial of insulin came in, indicating that the insulin vial had been opened on 03/20/25. Per manufacturers' (Eli Lilly) the guidelines for Humalog Mix 75/25 (https://uspi.lilly.com/humalog7525.html#ug), stated, "Opened Humalog mix 75/25 vials, prefilled pens, and cartridges must be thrown away 28 days after first use, even if they still contain insulin." his applies whether the vial is stored in the refrigerator or at room temperature."? A review of Resident #9 s medication record revealed the following: Resident #9 was admitted to the facility on 04/01/16 with diagnoses that included: Diabetes Mellitus, Atrial Fibrillation; Heart Failure; Hypothyroidism; and Gastroesophageal Reflux Disease (GERD). A physician's order dated 04/09/25 that directed: "Humalog Mix 75/25 Suspension (75-25) 100 units/ml, (units per milliliter) (Insulin Lispro Protamine and Lispro) Inject 20 units subcutaneously in the morning for diabetes AC (before a meal) Breakfast."	L 161	Tag: L161- Label/Store Drugs and Biologicals (pgs. 32-33) Identification of Other Residents: 1. A comprehensive audit of all medication storage areas will be completed by the unit manager/designee by 6/20/2025 to identify any other instances of improper storage of insulin vials, pens, and injectable medications. Any deficiencies noted will be corrected upon discovery. 2. Ensured all medications were properly labeled with open dates and checked for expiration. This will be completed by the unit manager/designee by 6/30/2025. 3. Unit managers/designee verified that medications belonging to discharged residents are removed promptly upon discharge by 6/30/25. Systemic Changes: 1. At least 80% of licensed nurses were re-educated by 6/30/2025 by the educator/designee on labeling and dating insulin vials and proper procedures for removing medications upon resident discharge. 2. The DON initiated updated procedures to ensure medications are checked for expiration dates and dated according to the manufacturer's recommendations by 6/30/25. Monitoring of Corrective Actions: The Unit Manager or designee will audit all medication storage areas for expired medications and correct labeling of insulin weekly for 4 weeks and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. Compliance will be reported and discussed during QAPI for continued oversight. Any trends identified will prompt further education or systems adjustment.	7/8/2025

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L 161	Continued From page 33 An April 2025 medication administration record (MAR) which documented that facility staff administered expired Humalog Mix 75/25 insulin to the Resident from 04/21/25 to 04/22/25. A review of Resident #9's blood sugar readings from 04/21/25 to 04/23/25 showed: 4/24/2025 08:47 88.0 mg/dL (milligram per deciliter) 4/23/2025 23:33 133.0 mg/dL 4/23/2025 16:52 127.0 mg/dL 4/23/2025 14:23 126.0 mg/dL 4/23/2025 14:18 89.0 mg/dL 4/23/2025 04:12 120.0 mg/dL 4/22/2025 15:43 83.0 mg/dL 4/22/2025 11:33 99.0 mg/dL 4/22/2025 08:30 94.0 mg/dL 4/21/2025 22:57 135.0 mg/dL 4/21/2025 15:19 198.0 mg/dL 4/21/2025 12:28 200.0 mg/dL 4/21/2025 10:14 245.0 mg/dL During a face-to-face interview on 04/09/25 with Employee # 45, a Licensed Practical Nurse assigned to Resident #9, he stated that he had not noticed that Resident #9 had expired insulin. He further said that he had not removed the insulin from the refrigerator and did not administer insulin to the Resident on 04/24/25 because his blood sugar before breakfast was 88 mg/dl. During a face-to-face interview with Employee #3/5th floor Unit Manager/Registered Nurse, she stated, "I take the responsibility for checking the refrigerator for expired medications." She then acknowledged the finding and said that she would discard the expired Humalog Mix 75/25 insulin from the refrigerator and order a new vial of	L 161		

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L 161	Continued From page 34 insulin for Resident #9. 2. On 04/24/25 at 12:48 PM during an observation of the 6th Floor Medication Storage Room, in the medication refrigerator, the following was observed: one(1) vial of Aspart (Novolog) insulin opened on 03/17/25 with no expiration date for Resident #64; one opened vial of Lantus insulin with no date for Resident #209; one opened vial of Lantus insulin with no date for Resident #77, and one opened Lantus insulin pen that showed approximately 20 units had been used with no date on it for Resident #259, who was discharged from the facility on 02/28/25. A. Resident #64 was re-admitted to the facility on 01/31/25 with a diagnosis that included: Metabolic Encephalopathy; Type 2 Diabetes Mellitus; End-Stage Renal Disease; Seizures, and Encounter for Gastostomy. A review of Resident #64's medication record showed the following: A physician's order dated 02/10/25 that directed: "Check Blood Sugar one time a day *Use Per Sliding Scale and Inject Subq (subcutaneously) * 1-150=0 units; 151-200=1 units; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; Call Physician (for) Blood Sugar greater than 400 for Diabetes Mellitus." The order was discontinued on 02/17/25. A physician's order dated 02/18/25 that directed: "Insulin Aspart Injection Solution (Insulin Aspart) Inject as per sliding scale: if 1 - 150 = 0 unit; 151 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units BS>400, Call MD (Physician), subcutaneously one time a day for diabetes, The order was	L 161		

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L 161	Continued From page 35 discontinued on 02/18/25 and was never renewed. Per manufacturers' (Novo Nordisk) guidelines for Novolog (insulin Aspart injection), (https://www.novolog.com/taking-novolog.html), opened vials of Novolog should be disposed after 28 days, even if there is insulin left in the pen or vial. A review of Resident#64's February 2025 medication administration records showed that facility staff had not administered Aspart to Resident #64 after 02/18/25. B.Resident #209 was admitted to the facility on 04/14/25 with diagnoses that included: Anoxic Brain Damage, Not Elsewhere Classified Metabolic Encephalopathy. Epilepsy and Type 2 Diabetes Mellitus Without Complications. A review of Resident #209's medical record showed: A physician's order dated 04/15/25 that documented: "Insulin Glargine Solution 100/ml. Inject 40 units subcutaneously two times a day for hyperglycemia." The physician discontinued the order on 04/22/24 and did not renew it. On 04/24/25, the Resident was discharged to the hospital and did not return to the facility. Two days later, the insulin was observed in the medication refrigerator. Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, "In-use (opened) Lantus vials or pens can be used for 28 days whether stored in the refrigerator or at room temperature."	L 161		

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L 161	Continued From page 36 A review of Resident#209's April 2025 medication administration records showed that facility staff administered Lantus insulin to the Resident from 04/15/25 to 04/22/25. Of note, the Resident's vial of Lantus insulin had no date indicating when it was opened or expired during this period. C.Resident #77 was admitted to the facility on 05/30/24 with diagnoses that included: Metabolic Encephalopathy; Type 2 Diabetes Mellitus Without Complications; Obstructive Hydrocephalus and Chronic Respiratory Failure. A review of Resident #77's medical record showed: A physician's order dated 03/23/25 that documented: "Lantus 100 unit/ml Solution. Inject 20 units subcutaneously two times a Day for Diabetes Mellitus." Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, "In-use (opened) Lantus vials can be used for 28 days whether stored in the refrigerator or at room temperature." A review of Resident#77's March and April 2025 medication administration records showed that facility staff administered Lantus insulin to the Resident from 03/23/25 to 04/24/25. On the note, the resident's vial of Lantus insulin was observed on 04/24/25 and stored in the medication refrigerator with no date indicating when facility staff opened it or when it expired. D. Resident #259 was admitted to the facility on 02/0725 diagnoses that included: Quadraplegia;	L 161		

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L 161	Continued From page 37 Type 2 Diabetes Mellitus Without Complication; Chronic Respiratory Failure; Anemia, Dysphagia, and Depression. A review of Resident #259's medical record showed: A physician's order dated 02/10/25 that documented: "Lantus SoloStar 100 UNIT/ML Solution pen-injector Inject 15 units subcutaneously one time a day at bedtime for Diabetes Mellitus Type 2," Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, "In-use (opened) Lantus Solostar pens should be used for 28 days, even if there is still insulin left in the pen." On 02/28/25, the Resident was transferred to the hospital and did not return to the facility. Approximately 57 days later, on 04/24/25, the Resident's insulin was observed in the medication refrigerator. During a face-to-face interview on 04/24/25 at 1:55 PM, Employee #6/ 6th Floor Unit Manager, was made aware of the open, undated, and expired insulin stored in commented the medication refrigerator in the Medication Storage Room. The Employee commented that each nurse is responsible for ensuring that all medications are in date before removing them from the medication refrigerator and certainly before administering the medication to the Resident. She added that the nurses are also responsible for ensuring that all medications for residents who have been discharged from the facility are removed from the medication	L 161		

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L 161	Continued From page 38 refrigerator and sent back to the pharmacy immediately. She further commented that if the nurse observes no date on an opened insulin vial or pen, the nurse is responsible for discarding the insulin and ordering a new vial or pen. The Employee then acknowledged the findings and stated that they would have an in-service meeting with the nurses on the unit about medication storage immediately after the interview.	L 161		
L 200	3231.11 Nursing Facilities Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 49 residents sampled, facility staff failed to have accurate documentation in Resident #209's medical record. The findings included: Resident #209 was admitted to the facility on 04/14/25 with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain Injury, and Metabolic Encephalopathy. Review of the resident's medical record revealed the following: 04/21/25 at 5:59 PM Situation Background Assessment and Request (SBAR): - Situation - Tachycardia with a pulse of 135 and an oxygen saturation of 85% - Comments: In the morning the resident had a pulse of 135 and his oxygen saturation was 85%, I informed Nurse Practitioner (NP), and she said to call 9-1-1, the resident was transferred via	L 200	Tag: L 200- Competent Nursing Staff (pgs. 39-40) Corrective Action for Residents Affected: Resident #73, the alarm was reviewed and resolved by the unit nurse on 4/13/25. The unit manager assigned to the floor provided immediate retraining to the assigned nursing staff on 4/13/25 on nurse aides not trained to troubleshoot issues related to G-tubes. Resident #209, no harm resulted from the deficiency. Immediate corrective training was provided to the nurse responsible for the SBAR documentation by the unit manager. Identification of Other Residents: 1. Residents with a change in condition and hospital transfers in the last 7 days were reviewed by the DON/designee to ensure an accurate and thorough completion of the SBAR to include current information documented in the resident's record. This was completed by 6/30/2025. 2. An audit of all nursing assistants was completed by the DON/designee to validate understanding of not troubleshooting medical devices such as G-Tubes. No additional deficiencies were noted.	07/8/2025

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L 200	Continued From page 39 Emergency Medical Services to [Hospital name]. A physician's order dated 04/21/25 directed, "Transfer to hospital." Review of the Medication and Treatment Administration Record for April 2025 showed that on 04/21/25, night shift (7:00 PM - 7:00 AM), the nurse documented a check mark and their initials to indicate that they took vital signs (including a blood glucose level), administered medications and treatments to Resident #209, who was no longer in the facility. During a face-to-face interview on 04/23/25 at 4:15 PM, with Employee #34 (assigned RN on 04/21/25) stated that Resident #209 left the facility around 9:00 AM on 04/21/25. The evidence showed that facility staff failed to have accurate documentation in Resident #209's medical record. During a face-to-face interview on 04/23/25 at 4:20 PM, Employee #2 (DON) reviewed Resident 209's medical record and acknowledged the findings.	L 200	Cont. Tag L 200- Competent Nursing Staff (pgs. 39-40) Systemic Changes: 1. The Facility HLOC report will be reviewed daily by the unit managers to identify residents with a change in condition and thorough completion of the SBAR and also to ensure PCC is updated with discharge status, accurate documentation of current information in the resident's record, and inability to document. Any deficiencies noted will be corrected upon discovery. 2. Nursing supervisors will be responsible for reviewing the SBAR for accuracy and completion with current information before physician notification. 3. At least 80% of licensed staff will receive training on accurately completing the SBAR with current information before physician notification by the educator/designee. Monitoring and Quality Assurance: The unit manager/designee will conduct audits of the SBARs in PointClick Care after a change in condition or resident transfer to the hospital, daily for 7 days, weekly for 4 weeks, and monthly for 3 months. Any deficiencies will be corrected upon discovery. Compliance and Outcomes will be reported and discussed during QAPI for continued oversight. Any trends identified will prompt further education or systems adjustment	7/8/2025
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a) The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b) Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor;	L 201		

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L 201	Continued From page 40 (c) Medicaid, Medicare and health insurance numbers; (d) Social security and other entitlement numbers; (e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f) Date of discharge, and condition on discharge; (g) Hospital discharge summaries or a transfer form from the attending physician; (h) Medical history and allergies; (i) Descriptions of physical examination, diagnosis and prognosis; (j) Rehabilitation potential; (k) Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l) Current status of resident's condition; (m) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n) The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final	L 201	Tag: L 201- Right to Request/Refuse/Discontinue Treatment; Formulate Advance Directives (pgs. 40-41) Corrective Action for Identified Resident(s): Residents #87, #56, #91, #74, and #73, and or their representatives have been provided with information regarding their rights to formulate or refuse an advance directive. This was completed on 6/13/2025 by the social worker. The medical records were reviewed and updated to ensure the accurate documentation of the provision of information regarding their rights to formulate or refuse an advance directive. The social worker and administrator were re-educated by the Regional Director of Operations on 6/30/2025 on resident rights to request, refuse, or discontinue treatment and formulate advance directives. Identification of Other Residents Who Could Be Affected: 1. A facility-wide audit of current residents' medical records will be completed by the Social Service Director on 6/16/2025 to ensure documentation of the provision of information regarding rights to formulate or refuse an advance directive. 2. No additional residents were identified without documentation of the provision of advance directives. A notification was sent to all current resident/families about their right to formulate an advanced directive via PCC by 07/8/2025 by Administrator in Training.	

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L 201	Continued From page 41 diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o) Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q) The plan of care; (r) Consent forms and advance directives; and (s) A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview, for five (5) of 49 residents sampled, facility staff failed to have documented evidence in the resident's medical record that included Advanced Directives. Residents' #87, #56, #91, #74, and #73. The findings included: Review of the facility's "Advanced Directives" policy dated 05/24/24 documented: - Upon admission, the resident will be provided with written information concerning the right to	L 201	Systemic Changes Put in Place to Ensure Non-Recurrence: 1. The Social Worker and administrator were re-educated by the Regional Director of Operations on the facility's policy related to treatment refusal, resident rights, and advance directives on 6/30/2025. 2. Verification of the resident's right to request/refuse/discontinue treatment; formulation of advance directives was integrated into the admissions process, quarterly care plan reviews, and upon change in condition. Monitoring of Corrective Actions to Ensure Effectiveness: The Social Services Director or designee will audit 25 resident records monthly for 3 months to ensure consistency between resident preferences, physician orders, and care plans. Any deficiencies noted will be corrected upon discovery. Findings will be reported to the QAPI Committee for further action as needed.	

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L 201	Continued From page 42 refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. - If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. - Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. - If the resident indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. 1. Resident #87 was admitted to the facility on 08/27/24 with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia. Review of the resident's medical record revealed the following: A face sheet that showed that listed the resident's daughter as her responsible party (RP), care conference person, emergency contact #1 and next of kin. A care plan focus area, last revised on 03/11/25 documented: [Resident #87] end of life wishes to remain a full code. Goal: Interdisciplinary team (IDT) team will honor [Resident #87's] wishes for end-of-life care. Interventions: Assist with pre-burial needs upon request; Honor spiritual and cultural wishes Inform resident of memorial services within the facility via flyer; Offer "5 Wishes (the facility's advanced directives form)" quarterly.	L 201		

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L 201	Continued From page 43 Review of Resident #87's medical record on 04/14/25 showed no documented evidence that the facility staff offered Resident #87's RP information to formulate or refuse to formulate an Advanced Directive. 2. Resident #56 was readmitted to the facility on 06/11/24 with multiple diagnoses that included: Amyotrophic Lateral Sclerosis (ALS) and Chronic Respiratory Failure with Hypoxia. Review of the resident's medical record revealed the following: A face sheet that listed the resident's sister listed as her RP, care conference person and emergency contact #1. 01/14/25 at 12:20 PM Care Conference Note: - A care plan meeting was held for the resident. - The resident is alert, oriented, and communicates using an assistive device. - The resident's sister participated by phone. - Will remain full code. - "Five Wishes" were offered to resident and placed in her room per her request. A care plan focus area last revised on 03/14/25 documented: [Resident #56] end of life wishes are to remain a full code. Goal: IDT team will honor [Resident #56's] wishes for end-of-life care. Interventions: Honor spiritual and cultural wishes; Offer "5 Wishes" quarterly. Review of Resident #56's medical record on 04/14/25 showed no documented evidence that the facility staff offered Resident #56 or her RP information to formulate or refuse to formulate an Advanced Directive.	L 201		

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L 201	Continued From page 44 3. Resident #91 was admitted to the facility on 01/29/25 with multiple diagnoses that included: Interstitial Pulmonary Disease, Type 2 Diabetes Mellitus and Chronic Respiratory Failure. Review of the resident's medical record revealed the following: A face sheet that showed that she was her on responsible party. An Admission Minimum Data Set (MDS) assessment dated 02/04/25 showed that facility staff coded: adequate hearing; clear speech; makes self-understood; understands others; and a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact cognitive response. A care plan focus area revised on 03/17/25, [Resident #91] end of life wishes to be a full code, had interventions that included: assist with pre-burial needs upon request; honor spiritual and cultural wishes; and offer "5 Wishes" quarterly. Review of the resident's medical record on 04/14/25 showed no documented evidence that the facility staff offered Resident #91 information to formulate or refuse to formulate an Advanced Directive. 4. Resident #74 was admitted to the facility on 04/16/24 with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure with Hypoxia and Type 2 Diabetes Mellitus. Review of the resident's medical record revealed the following:	L 201		

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L 201	Continued From page 45 A face sheet that listed the resident's daughter as her RP, care conference person and emergency contact #1. A care plan focus area revised on 04/07/25 documented: Family wishes for [Resident #74] to be a do not resuscitate (DNR). Goal: IDT team will honor family end of life wishes as a communicated by family. Interventions: Provide advanced care planning information to family; Provide spiritual care in accordance with family's faith; Review "5 Wishes" with resident and family quarterly. Review of the resident's medical record on 04/14/25 showed no documented evidence that facility staff offered Resident #74's RP information to formulate or refuse to formulate an Advanced Directive. 5. Resident #73 was admitted to the facility on 04/04/24 with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure, and Adult Failure to Thrive. Review of the resident's medical record revealed the following: A face sheet that listed that she had a had a legal guardian who is her RP and emergency contact #1. A care plan focus area, last revised on 0317/25 documented: Guardian end of life wishes for the resident to remain a full code. Goal: The IDT team will honor the wishes for end-of-life care. Interventions: Honor spiritual and cultural wishes; Offer "5 Wishes" quarterly.	L 201		

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L 201	Continued From page 46 Review of Resident #73's medical record on 04/14/25 showed no documented evidence that the facility staff offered the resident's guardian information to formulate or refuse to formulate an Advanced Directive. During a face-to-face interview on 04/14/25 at 12:17 PM, Employee #18 (Director of Social Services) acknowledged the findings and stated, "I leave the advanced directive form (5 wishes) in the room for the resident or their RP. Once it's filled out, the resident or the family will give us (Social Services Department) a call to come get it." When asked who follows up if the advanced directive is not returned to the Social Services Department, Employee #18 stated that there is no follow-up done by him or anyone else in the Social Services Department if the Advanced Directive forms are not completed by the resident or their family/representative.	L 201	Tag: L 204- Investigation of Alleged Abuse, Neglect, Exploitation (pgs. 47-48) Corrective Action for Identified Resident(s): Resident #87 was discharged on 6/12/2025. The administrator reached out to the family on 6/17/2025 to provide a receipt so the cellphone will be replaced. A follow up investigation was initiated on 6/16/25 by the administrator to ensure additional staff on the 5th floor who worked on 12/2/2024 are interviewed and completed on 6/19/25. The results of the incident were documented, and the findings were shared with the resident and the responsible party. Resident #81 was involved in an allegation of staff-to-resident abuse. The staff member was removed from duty immediately. Resident #81 was interviewed and assessed; no physical injury was observed. A thorough investigation was conducted, including interviews with involved parties, documentation review, and will submit of findings to the State Agency by 6/18/2025.	
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a) The date, time, and description of the incident; (b) The name of the witnesses; (c) The statement of the victim; (d) A statement indicating whether there is a pattern of occurrence; and	L 204		

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L 204	Continued From page 47 (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on record review and staff interviews, for two (2) of 49 residents sampled, facility staff failed to have documented evidence that they conducted thorough investigations for one resident's missing cellphone and one resident's allegation staff-to resident verbal abuse. Residents' #87 and #81. The findings included: Review of the facility's "Abuse Investigation and Reporting" policy dated 05/24/24 documented: - All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. - The role of the investigator includes interviewing staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. 1. Facility staff failed to have documented evidence that all staff listed on the 5th floor assignment on the date of the incident (12/02/24) were interviewed or provided a statement, to include housekeeping and activities personnel, who were potential witnesses, as part of the facility's investigation. Resident #87 was admitted to the facility on 08/27/24 with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia, Asthma, Muscle	L 204	Cont. Tag: L 204- Investigation of Alleged Abuse, Neglect, Exploitation (pgs. 47-48) Identification of Other Residents: 100% of residents with documented allegations of abuse or incidents over the past 30 days will be reviewed on 6/18/2025 by Administrator or designee to ensure investigations were completed thoroughly and on time. The review included audits of abuse logs, grievance records, and 24-hour reports. Any additional allegations found during the audit process will be reviewed for thoroughness and completeness. Systemic Changes: 1. The facility's policy and procedure for conducting and documenting investigations were reviewed with the Interdisciplinary Team and all department heads by the educator/designee by 7/8/25. 2. A standardized abuse/neglect investigation tool was implemented on 5/24/24 to ensure all elements (timelines, documentation, interviews of staff) are consistently followed. 3. The abuse coordinator was re-educated on the standardized abuse investigation tool by the Regional Director of Operations by 7/8/25. Monitoring of Corrective Actions: The Administrator or designee will audit 100% of new abuse/neglect investigations weekly for 4 weeks and monthly for 3 months to ensure timely notification, initiation of investigation, thorough documentation, and resolution of all allegations of abuse. Any deficiencies noted will be corrected upon discovery. Audit outcomes will be reviewed during monthly QAPI meetings. Any trends identified will prompt further education or systems adjustments.	7/8/2025

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L 204	Continued From page 48 Weakness. Review of the resident's medical record revealed the following: A face sheet that showed that the resident's daughter listed as her responsible party (RP), care conference person, emergency contact #1 and next of kin. A Significant Change Minimum Data Set (MDS) assessment dated 11/21/24 showed that facility staff coded: clear speech; makes self understood; clear comprehension of others; adequate vision; a Brief Interview for Mental Status (BIMS) summary score of 12, indicating mild cognitive impairment; no behavioral symptoms; and no functional impairment in range of motion in upper extremities. A Facility Reported Incident (FRI), DC~13314, submitted to the State Agency on 12/03/24 documented, - On December 2nd, 2024, at approximately 4:30 PM, [Resident #87] complained that she could not find her Samsung cell phone when she woke up from sleep at around 4:00 PM. A follow-up to FRI DC~13314, submitted to the State Agency on 12/09/24 documented: - This is the conclusion of the self-report that was sent on 12/03/24. - During the investigation, staff were interviewed. - Based on the facility investigation, facility was unable to substantiate how the cell phone went missing. Review of the facility's investigation documents on 04/23/25 showed that not all the staff listed on the 5th floor assignment on the date of the	L 204		

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L 204	Continued From page 49 incident (12/02/24) were interviewed or provided a statement, to include housekeeping and activities personnel, as part of the facility's investigation. The evidence showed that the facility staff failed to conduct a thorough investigation of Resident #87's missing cellphone. During a face-to-face interview on 04/23/25 at 11:44 AM, Employee #1 (Administrator/Abuse Coordinator) and Employee #2 (Director of Nursing/DON) reviewed the investigation documents and acknowledged the findings. 2. Resident #81 was admitted to the facility on 05/30/24 with diagnoses that included: Cerebral Infarction, Hemiplegia and Hemiparesis, Facial Weakness, Aphasia, Epilepsy, Chronic Respiratory Failure, Tracheostomy Status, Gastrostomy Status, Altered Mental Status, and Anxiety. A review of Resident #81's medical record revealed: A Quarterly minimum data set (MDS) assessment dated 03/17/25 that documented that the Resident had a Brief Interview for Mental Status (BIMS) of, "07" indicating that the Resident had severely impaired cognition. A physician's order dated 03/10/25 that directed: "Psych Consult and PRN one time only for Evaluation/ Reassessment for 3 Days A Psych Progress Note dated 03/12/25 that	L 204		

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L 204	Continued From page 50 documented: "1. Mood, and behavior:..the patient is not a good historian and exhibits a combination of thought blocking and confusion. Given memory impairment, she remains vulnerable to agitation and care issues. No exacerbation of agitation was noted. The precipitating and perpetuating factors are a decline in health and memory. No evidence of active or passive SI (suicidal ideation) was noted. The patient denied overt s/s (signs and symptoms) of depression or psychosis. No evidence of mania or psychosis was noted ..." A physician's order dated 03/16/25 at 7: 00 AM that directed: "Behaviors - Monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift." A physician's order dated 03/17/25 at 9:00 PM that directed: "Trazodone HCl Oral Tablet 50 mg (milligrams). Give 1 tablet by mouth at bedtime for anxiety and difficulty sleeping." A physician's order dated 03/25/25 at 1:00 PM that documented: "Clonazepam Oral Tablet 0.5 mg. Give 1 tablet by mouth three times a day for anxiety for 15 days." A review of a facility reported incident (DC~13619) dated 04/17/25 that documented: " Initial report: At approximately 7:25 PM, Resident son in [Resident 381's room] stated that while using the bathroom in the patient('s) room that he heard someone used the word [expletive] on his	L 204		

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L 204	Continued From page 51 mother. investigation is ongoing... A follow-up report dated 04/23/25 documented; "This is the follow-up of the self-report that was submitted on 04/17/2025. On 04/17/2025, at around 07:25 PM, [Resident # 81's son] reported that while he was in (his) mother (s) bathroom, A nurse came in to bring my/his mom her food, the nurse called her a girl, and my mom said she wasn't a girl and rejected her food. The nurse then called her [expletive] and walked out "... Staff were interviewed, and statements were obtained ... "Her son, who initially reported the incident, confirmed that he overheard the comment from the bathroom but was unable to identify the specific staff member involved. During a follow-up on April 20, 2025, he maintained that he could not confirm who made the comment. Based on the statements and staff interviewed, none of the staff reported witnessing or hearing anyone referring to the resident using derogatory language on 04/17/2025. Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse ...This is the final report." A review of the facility's investigation packet included the written statements of two CNAs, in response to the question: Was there any incident at all that you witnessed a staff member named [Employee #28/alleged perpetrator] (Nursing Assistant) treated any of the residents in any way that may indicate any form of abuse. Example: involuntary seclusion, financial, neglect physical, verbal, sexual, mental, or emotional abuse? 1) Employee #32 written statement response to the question dated 04/21/25 was: "Answer: Yes" "Comments: The CNA was passing trays, [Room of alleged victim/resident] came to the door. The	L 204		

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L 204	Continued From page 52 CNA said, 'Oh you scared me. The resident said, "I didn't do anything. The CNA said you crazy you talk to yourself. The resident said, yes, that's why I take medicine.' She laughed and the resident said if it's a problem, don't come back to my room. The CNA 's name is [Name of Employee #28/alleged perpetrator]." 2) Employee #29's written statement/response: dated 04/22/25 was: "Answer: Yes." "Comments: I overheard her talk to {Name of alleged victim/resident] any kind of way. The words were. 'I don't have time [expletive], [Name of alleged victim/resident]. I will [expletive] you up if you touch me." The summary and analysis of the facility's investigation to the incident involving Resident #81 and Employee #28 was submitted to the state agency on 04/23/25 and concluded, " ...Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse ...This is the final report." The facility's summary and analysis of the incident failed to include a statement indicating that there was a pattern of occurrence based on Employee # 32 and #29's statements that alleged Employee #28's verbal abuse toward two other residents. During a face-to-face interview on 04/28/25 at 9:44 AM, Employee #2/ Director of Nursing stated that the facility was in receipt of the two CNA responses which alleged that Employee #28 , had verbally abused two other residents before submitting the final report of the alleged incident of verbal abuse between Employee #28 and Resident #81 to the State agency on 04/23/25.	L 204		

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L 204	Continued From page 53 Employee #2 further stated that as a result of the CNA statements, two new investigations alleging that Employee #28 had verbally abused two other residents were initiated. Employee #2, then acknowledged that although the facility stated that " ...Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse ...,on 04/26/25 the facility initiated two new investigations of Employee #28's alleged verbal abuse toward two other residents. Employee #2 then acknowledged that the facility's summary and analysis of the incident failed to include a statement indicating that there was a pattern of alleged verbal abuse by Employee #28 towards residents.	L 204		
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, and interview, facility staff failed to ensure that the environment remains free of pest as evidenced by three (3) of three (3) mouse traps that were observed around the cook line, one (1) of one (1)mouse trap and mouse droppings in the dishwashing machine room, and flying pest in the three-compartment sink area. The findings included: 1. Three (3) of three (3) mouse traps were observed around the cook line, behind one (1) of one (1) grill and one (1) of one (1) gas stove, and one (1) of one (1)	L 426	Tag: L 426- Maintains Effective Pest Control Program (pgs. 54-55) Corrective Action for Residents Affected: 1. The mouse droppings were cleaned from the cook line and dishwashing machine room on 4/13/2025. 2. The areas were thoroughly cleaned and sanitized on 4/14/2025 by EVS. 3. A pest control service was done on 4/14/25 to address the issues identified during the survey and is ongoing. 4. A professional pest control service was contacted and conducted an immediate inspection and treatment of the affected areas to eliminate any existing pest issues on 4/14/2025. Identification of Other Residents: 1. A comprehensive inspection of the kitchen and dishwashing area was conducted on 4/14/2025 to identify any other areas that may be affected by pest issues. No additional areas were identified. 2. Additional pest control measures were implemented throughout the facility on 4/14/2025, including sealing potential entry points and increasing the frequency of pest control treatments.	07/8/2025

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L 426	Continued From page 54 mouse trap and mouse droppings were seen in a corner area of the dishwashing machine room. 2. Flying insects that appear to be gnats were observed in the area where the three-compartment sink is located, sporadically throughout the kitchen. Employee #37 acknowledged the findings during a face-to-face interview on April 17, 2025, at approximately 3:00 PM.	L 426	Cont. Tag: L 426- Maintains Effective Pest Control Program (pgs. 54-55) Systemic Changes: 1. The facility reviewed its pest control contract to ensure scope and frequency met best practice standards. The contract met standards, however the facility decided to increase pest control visits. 2. Environmental Services and Dietary staff were re-educated on pest prevention practices, including food storage, trash handling, and cleaning protocols by the educator/designee by 7/8/25. 3. A pest control log was implemented in the kitchen for real-time reporting. Preventative pest control service frequency was increased from monthly to weekly. Monitoring of Corrective Actions: The Maintenance Director or designee will perform weekly environmental inspections of all resident care and storage areas for 4 weeks and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. Compliance and Outcome will be discussed during QAPI for continued oversight. Any trends identified will prompt further education or systems adjustment.	
L 521	3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by: Based on record review and staff and family interview, for one (1) of 49 sampled residents, the facility's staff failed to have documented evidence a resident was treated with dignity and respect following an allegation of staff-to-resident verbal abuse. (Resident #158) The findings included: Resident #158 was admitted on 03/06/24 with multiple diagnoses including Altered Mental Status, Muscle Weakness, and Psychotic Disorder. During a telephone interview related to different concern (Complaint DC~12827) on 04/25/25 at approximately 10 AM, the resident daughter (complainant) stated that Employee #39 (CNA) said, "My mom was pistol in front of my mom.	L 521	Tag. L 521- Free from Abuse and Neglect, Dignity and respect (pgs. 55-56) Corrective Action for Identified Resident(s): 1. Upon receiving the allegation, an immediate investigation was initiated to investigate the situation involving Resident #158. 2. The investigation was completed on 5/6/2024 and documented in the abuse investigation folder. Employee #39 was immediately removed from the schedule pending the outcome of the investigation. 3. Records of alleged abuse investigations are currently secured at the Administrator's office.	7/8/2025

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L 521	Continued From page 55 After the employee said my mom was afraid and wanted to go home." The resident's daughter then said, "I told her [Employee #39] that I would not tolerate any mistreatment of my mom. And then the employee said that she could tell I was from the streets." Additionally, the resident's daughter said that she made the Administrator aware and she never saw Employee #39 again. It should be noted that the resident's daughter could not remember the specific date of the incident. On 04/24/25 at approximately 11 AM, a review of Resident #158's medical record and the facility's incident binder lacked documented evidence of alleged incident of verbal abuse. During a face-to-face interview on 04/29/25 at 6:20 AM, Employee #39 stated that the Administrator and Human Resource Director called her into a few months. The meeting was held because Resident #158's daughter said, "I verbally abused her and her mom." The employee stated that she did not verbally abuse anyone. She was suspended for 2 day during the investigation and moved to a different floor when she returned to work. During a face-to-face interview on 04/29/25 at approximately 10 AM, Employee #1 (Administrator) stated that he remembered the incident. The employee said that they conducted an investigation and could not substantiate that staff-to-resident verbal abuse occurred. However, the employee said that the Human Resource's Director who no longer works for the facility had the investigation documents. And he was not able to locate them. Additonally, the employee said that Empployee #39 (CNA) was suspended while the investgation was conducted, and she was	L 521	Cont. Tag: L521- Free from Abuse and Neglect, Dignity and respect (pgs. 55-56) Identification of Other Residents Who Could Be Affected: 1. All allegations of abuse in the past 4 weeks will be reviewed by the Administrator and DON by 6/30/2025 to assure investigations are complete and noted in the medical records. 2. 2. Areas of non-compliance during the audits will be addressed upon identification. 3. All abuse investigation records are currently secured at the Administrator's office. 4. Any additional allegations of abuse identified during the audit will be reviewed to include a complete and thorough investigation. Systemic Changes: 1. The facility abuse prevention policy was reviewed and updated by 6/30/2025 by the Administrator/DON to ensure clarity in reporting and documentation procedures. 2. At least 80% of the current facility staff will be provided training on the abuse prevention policy by the educator/designee. 3. A checklist has been developed to ensure completion and documentation of the abuse investigation, reporting, and documentation process. Monitoring of Corrective Actions: 1. The Administrator or designee will review 50% of all alleged abuse investigations weekly for 4 weeks and monthly for 3 months for documented evidence of investigation and conclusion. Any deficiencies noted will be corrected upon discovery. 2. The Abuse Coordinator will monitor for unreported concerns. Trends and outcomes will be reviewed by the QAPI Committee. Any trends identified will prompt further education or systems adjustments.	7/2/2025

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L 521	Continued From page 56 moved to another floor when she returned to work.	L 521		