STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL CITY REHAB AND HEALTHCARE CENTER	2425 25TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced survey was conducted at this facility from 06/12/24 to 06/20/24. Survey activities consisted of observations, record review, resident, staff and family interviews. The facility's census on the first day of the survey was 277 and the sample included nine (9) residents. Substandard Quality of Care was identified and the survey team conducted an extended survey on June 19, 2024. The following complaints were investigated during this survey: DC~12888 and DC~ 12902. The following Facility Reported Incidents were investigated during this survey: DC~12732, DC~12873, DC~12874, and DC~12884. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long-Term Care Facilities. Citations are being cited for intakes: DC~ 12902, DC~12873, DC~12874, and DC~12888. During this survey, an Immediate Jeopardy (IJ) was identified at 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation (F600) on June 18, 2024, at 10:31 AM. The facility provided a plan of action to address the immediate concerns on June 18, 2024, at 5:44 PM and it was accepted. After the plan was verified, the IJ was removed on June 20, 2024 at 5:25 PM while the survey team was onsite. The following is a directory of abbreviations and/or acronyms that may be utilized in the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/1/2024

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

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F 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)	F 000		

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F 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 QIS - Quality Indicator Survey 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	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and	F 558		

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F 558	Continued From page 3 preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of nine (9) sampled residents, facility staff failed to ensure that reasonable accommodations for a room assignment was provided for a resident that did not endanger his health or safety as evidenced by placing Resident #2 (new admission), with a known history of physically aggressive behaviors toward other residents, in a room with Resident #1, also with a known history of physical aggression towards other residents and staff. The findings included: Resident #2 Background: Resident #2 was previously admitted to the facility on 01/27/22 with multiple diagnoses that included: Schizophrenia, Metabolic Encephalopathy and Muscle Weakness. Review of the resident's medical record showed the following: A census tracking sheet that showed he resided on unit 3 south, room 340 bed B since 02/14/22. A Nursing Note dated 03/04/24 at 9:59 AM that documented: - Writer was informed that [Resident #2] pushed Resident #3 out of his wheelchair causing the resident to fall on the floor in the hallway. - Police and Crisis support were informed.	F 558	F558 **1.Corrective Action** Resident #1 was discharged on 6/8/2024. This deficient practice cannot be retroactively addressed for Resident #1. Resident #2 was offered emotional and psych support by social services and Arising Psych Services on 6/10/2024. Resident declined both services. Care plan for refusals of care was revised on 6/14/2024 to include the resident's refusal of those services. Psych services will continue monthly and as needed. The Administrator/designee reviewed and revised the current process for bed assignments for new admissions, readmissions and room relocations in order to protect residents from potential abuse on 6/20/2024. **2.Identifying Other Residents** All residents have the potential of being affected by reasonable accommodations for room assignments not being made. The Administrator/designee reviewed and revised the current process for bed assignments for new admissions, readmissions and room relocations in order to protect residents from potential abuse on 6/18/2024. The Administrator/ Designee conducted a review for complaints/grievances related to roommate compatibility within the last 30 days on 6/19/2024. Alternate options within residents rights, as related to F558 were offered immediately.	7/29/2024

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F 558	Continued From page 4 A physician's order dated 03/04/24 directed, "Transfer resident to the nearest psych[iatric] hospital for evaluation." Resident #2 was transferred out of the facility via FD-12 (application form used for the emergency admission of an individual in need of immediate psychiatric evaluation) on 03/05/24. Resident #1 Background: Resident #1 was admitted to the facility on 07/02/21 with multiple diagnoses that included Anxiety, Schizophrenia, and Depression. Review of the resident's medical record revealed: Resident #1 was admitted to the facility on 07/02/21 with multiple diagnoses that included Anxiety, Schizophrenia, and Depression. A care plan initiated on 05/02/24, documented in part " Focus area- On 5/1/2024 - Alleged physical aggression towards another resident while both residents were on LOA (leave of absence)...Interventions - Continue with 1:1 monitoring; Psych consult to evaluate." Sequence of events: An Admission Summary dated 06/06/24 at 10:37 PM documented: - [Resident #2] readmitted [to unit 2 south, room ###, bed #] today from [Psychiatric Hospital Name]. - Resident came into the facility ambulating at about 3:45 PM with his personal belongings. - Resident refused complete physical assessment and skin assessment, refused weight and	F 558	F558 Cont. **3.Systemic Change** Administrator, Assistant Administrator, DON, ADON, Unit Managers, Nursing Supervisors, Social Services and Guest Services were educated by Regional Clinical Consultant/Designee on resident compatibility/agreement, to include documented aggressive behaviors, to ensure that room placements are appropriate and residents are protected from physical, psychosocial harm as well as additional abuse on 06/18/2024 and 06/20/2024. New Admissions personnel will be educated on resident compatibility/ agreement during orientation. **4.Monitoring Corrective Action** Unit Managers/Designee will review new, readmissions and current residents for compatibility/agreement, with considerations from F558, weekly x 4 then monthly x 3. Roommate incompatibility will be addressed immediately. Findings will be reported to QAPI monthly x3 months for review and recommendations to maintain substantial compliance.	7/29/2024

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F 558	Continued From page 5 inventory of his personal belongings on admission. A care plan focus area initiated on 06/06/24 documented, "[Resident #2] had an episode of physical aggression towards another resident on 10/01/23. [Resident #2] had an additional episode of physical aggression against another resident on 03/04/24" had interventions that included but not limited to: hourly monitoring for 72 hours. A Nurses Note dated 06/8/24 at 10:57 PM documented, "Resident to Resident Altercation: At about 6:45 pm a report was received from staff stating that this resident [Resident #2] was actively having a physical altercation with another resident (resident's roommate/[Resident #1]) ... DC (District of Columbia) Metropolitan Police were called at 6:50 pm and the police, including EMS (emergency medical services), arrived at the unit at about 6:55 pm... Resident (#2) was noted bleeding from his left leg but was unsure of where the bleeding was coming from. When paramedics found where the bleeding was coming from, he was quickly transported to [Hospital Name] for evaluation and treatment ..." The Hospital Discharge Summary for Resident #2 dated 06/08/24 documented: - Seen today for stab wound of leg, laceration. A Nursing Note for Resident #2 dated 06/09/24 at 1:45 AM documented: - Received a call from [Hospital Name] at 8:45 PM and was informed that the resident has 3 stiches underneath his left knee. - At about 10:50 PM, the resident was brought in via stretcher.	F 558		

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F 558	Continued From page 6 During a face-to-face interview on 06/12/24 at 3:40 PM, Employee #7 (External Marketing Liaison/Admissions Department) stated that: - She is not a nurse, nor does she have a clinical background. - She has been covering for the Admission's Director for the last 3 to 4 months. -The resident's placement to a room is based off the facility's availability of beds and on clinical compatibility, such as isolation. - She makes the determination of the resident's room placement. - This is the first time that she was not a part of a resident's admission. However, she was aware that the Administrator and DON (Director of Nursing) were discussing Resident #2's return to the facility. - On 06/06/24, the facility had only two male beds available. During a face-to-face interview on 06/13/24 at 5:17 PM with Employee #2 (Director of Nursing/DON) stated on 06/06/24, he received information about available beds from the Admissions Department. He was informed by the Admissions Department that [Room 220 Bed A] was available. The employee also stated that he did not think the room was suitable for Resident #2 because of the roomate's [Resident #1] unpredictable behaviors. However, he said he was temporarily placing Resident #2 in that room until he was able to find a more suitable room. Additionally, he informed the Administrator of his concerns. At the time of the interview, the surveyor showed Employee #2 the facility's resident census reports dated 06/05/24 and 06/06/24, which showed	F 558		

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F 558	Continued From page 7 another room [Room 260 Bed B] was available when Resident #2 was admitted. According to the employee, the Admissions Department did not notify him that Room 260 Bed B was available. The employee was then asked if Room 260 Bed B would have been a more suitable choice for the resident? Employee #2 answered, "Yes." The evidence showed that the facility staff failed to ensure that reasonable accommodations for a room assignment was provided for Resident #2's health or safety. Subsequently, on 06/08/24 at approximately 6:45 PM, Resident #1 and Resident #2, were involved in a physical altercation, that resulted in Resident #2 sustaining a stab wound on his left leg that required medical intervention (stiches).	F 558		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for	F 559		

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F 559	Continued From page 8 one (1) of nine (9) sampled residents, the facility's staff failed to provide a resident with written notice that a new roommate had been assigned to his room on 06/06/24. (Resident #1). The findings included: Resident #1 was admitted to the facility on 07/02/21 with multiple diagnoses including Schizoaffective Disorder, Anxiety, and Depression. A quarterly Minimum Data Set dated 03/04/24 documented in part, the resident had a Brief Interview for Mental Status summary score of "15" indicating that the resident's cognitive status was intact. The resident was coded for having physical behaviors (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) directed toward others, verbal behaviors (e.g., threatening others, screaming at others, cursing at others) directed toward other, and rejection of care. Also, the resident was coded for using anti-psychotic medications on a routine basis. A care plan dated 05/01/24 documented in part, "Focus area- alleged physical aggression towards another resident of [Room #] while both residents were on LOA (leave of absence) ...Interventions-Psych[iatric] consult ...continue 1:1 monitoring ...resident was arrested ..." A care plan dated 05/16/24 documented in part, "Focus area - verbal aggression towards nursing staff, going around nursing station, attempted to pick up the hole puncher. Interventions- 911 was called ...no arrest was made ...continue with 1:1 monitoring ...staff de-escalated the situation ..."	F 559	F559 **1.Corrective Action** Resident #1 was discharged on 6/8/2024. This deficient practice cannot be retroactively addressed for Resident #1. The Administrator/designee reviewed and revised the current process for bed assignments for new admissions, readmissions and room relocations in order to protect residents from potential abuse on 6/20/2024. **2.Identifying Other Residents** All residents have the potential of being affected by not being notified in writing of roommate assignments. On 6/20/2024 the Administrator/designee reviewed and revised the current process for bed assignments for new admissions, readmissions and room relocations, to include notification of Residents/ Responsible party of new roommates in writing. The Administrator/Designee conducted a review for complaints/ grievances related to roommate compatibility within the last 30 days on 6/19/2024. Two room relocations were processed based on audit findings.	7/29/2024

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F 559	Continued From page 9 A review of the resident's medical record lacked documented evidence that facility staff provided him with written notification that he was getting a new roommate [Resident #2]. During a face-to-face interview on 06/17/24 at approximately 3:30 PM, Employee #2 (DON) stated that Resident #1 was not notified in writing that he was getting a new roommate [Resident #2]. However, he did verbally inform Resident #1 about his new roommate after he returned from leave of absence. It should be noted a Leave of Absence sign-out sheet dated 06/06/24 revealed that Resident #1 left the facility at 2:08 PM and returned at 6:55 PM.	F 559	F559 Cont. **3.Systemic Change** Administrator, Assistant Administrator, DON, ADON, Unit Managers, Nursing Supervisors, Social Services and Guest Services were educated by Regional Clinical Consultant/Designee on resident notifications and agreement, to ensure that room placements are appropriate and residents are protected from physical, psychosocial harm as well as additional abuse on 6/18/24 and 6/20/24. **4.Monitoring Corrective Action** Unit Managers/ Designee will audit new, readmissions and current residents for agreement with roommate assignments, with considerations from F559, weekly x4 then monthly x3. Deficient findings will be addressed immediately. Findings will be reported to QAPI monthly x3 months for review and recommendations to maintain substantial compliance.	7/29/2024
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and a resident's interview, for three (3) of nine (9) sampled residents, the facility failed to	F 600		

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F 600	Continued From page 10 ensure residents were free from physical abuse as evidenced by: (1) The Administrative staff making the decision to place Resident #2 (new admission), who was known for physical aggressive behaviors toward other residents, in a room with Resident #1, who was also known for physical aggression against other residents and staff and sexual misconduct. Subsequently, on 06/08/24, Resident #1 and Resident #2 were involved in a physical altercation which resulted in Resident #2 sustaining a stab wound to his left leg; and (2) An altercation on 06/15/24 between Employee #9 and Resident #4 led to the employee throwing lemonade and ice in the resident's face. Residents' #1, #2, and #4. Due to these failures, an Immediate Jeopardy (IJ) was identified at 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation (F600) on June 18, 2024, at 10:31 AM. The facility provided a plan of corrective action to address the immediate concerns on June 18, 2024, at 5:44 PM and it was accepted by the State Agency's survey team. After the plan was verified, the IJ was removed on June 20, 2024, at 5:25 PM while the survey team was onsite. After the removal of the immediacy, the deficient practice remained at actual harm at the scope and severity of a "G". These failures resulted in actual harm to Resident #2 on 06/08/24, a stab wound to his left leg, that required stitches. The findings included:	F 600	F600 **1.Corrective Action** Resident #1 was discharged on 6/8/2024. Resident #2 was offered emotional and psych support by social services and Arising Psych Services on 6/10/2024. Resident #2 was offered emotional and psych support by social services and Arising Psych Services on 6/10/2024. Resident declined both services. Care plan for refusals of care was revised on 6/14/2024 to include the resident's refusal of those services. Psych services will continue monthly and as needed. Resident #4 declined physician evaluation on 6/16/2024. Resident #4 was seen by Social Services for emotional support on 6/17/2024. Employee # 4 was terminated on 6/27/2024; reported to state licensing agency for abuse on 7/24/2024.	7/29/2024

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F 600	Continued From page 11 A review of the facility's "Abuse, Neglect and Exploitation" policy dated 01/04/24 documented, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written procedures that prohibits and prevent abuse and neglect of residents ...The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse." 1. Facility staff failed to ensure Residents #1 and #2 were free from physical. Background information for Resident #2: Resident #2 was previously admitted to the facility on 01/27/22 with multiple diagnoses that included: Schizophrenia, Metabolic Encephalopathy and Muscle Weakness. A nursing progress note dated 10/01/23 at 6:30 AM documented, "At about 6:30 AM, [Resident #2] pushed [Resident #3] in the hallway and slapped him on the right side of jaw. The charge nurse rushed and separated both residents. [Resident #2] noncompliant and non-cooperative, refused to open his door to speak to the police officer. Nurse Practitioner notified and recommendation for psych consult given for resident with aggressive behavior." A behavior progress note dated 02/19/24 at 11:17 AM documented, "Writer observed resident walked into [Resident #3 s] room, opened the window curtain, set the room temperature to 80 degrees and took a pair of [Resident #3's] shoes	F 600	F600 Cont. **2.Identifying Other Residents** All residents have the potential of being affected by not being free from Abuse. DON/Designee conducted an audit to identify all residents with documented aggressive behaviors that could lead to abuse of another resident. The Administrator/designee conducted a review of current residents to determine if there are any documented complaints or grievances within the last 30 days on 6/19/2024 related to roommate combability/agreement. DON/Designee conducted an audit of facility reported incidents to ensure there were no other cases of staff to resident interactions. Findings were addressed immediately. 3.**Systemic Change** New and current employees will be educated on Abuse by the Staff Educator/ Designee. **4.Monitoring Corrective Action** Social Services Director/Designee will conduct audits to review complaints/ grievances to ensure that instances/ allegations of abuse were addressed appropriately weekly x4 monthly x3. Findings will be addressed immediately and reported to QAPI monthly x3 months for review and recommendations to maintain substantial compliance.	7/29/2024

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F 600	Continued From page 12 back to his room. Writer called other staff for assistance, but resident refused to give back the shoes. [Resident #2] was cursing at multiple staff members and became very hostile and intimidating. Resident #2 stated, "I don't know why he [Resident #3] is still alive." Resident repeated the statement more than two times." A behavior progress note dated 02/21/24 at 11:43 PM documented, "Resident asked for a razor blades at around 10:55 PM, writer told him just to shave in the morning so CNA (Certified Nurse Aide) can assist or help him, but he said, "I know where the razors are, I will get some." He went to the supply room, pushed the door and grabbed razors, nobody can stop him." A nursing progress note dated 03/04/24 at 9:59 AM documented, "Writer was informed that [Resident #2] pushed [Resident #3] out of his wheelchair causing the resident to fall on the floor in the hallway. Police and Crisis support were informed." A physician's order dated 03/04/24 directed, "Transfer resident to the nearest psych hospital for evaluation." Resident #2 was transferred out of the facility via FD-12 (application form used for the emergency admission of an individual in need of immediate psychiatric evaluation) on 03/05/24. Review of the medical record showed that Resident #2 was re-admitted to the facility on 06/06/24 to unit 2 south, room 220 bed A. Background information for Resident #1:	F 600		

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F 600	Continued From page 13 Resident #1 was admitted to the facility on 07/02/21, with multiple diagnoses that included Anxiety, Schizophrenia, and Depression. The facility's census tracking form showed that Resident #1 resided on unit 2 south, room 220 bed B since 09/06/23. A care plan revised on 12/27/23 documented, "[Resident #1] is on 1:1 monitoring for allegations of inappropriate touching of a female resident. Interventions included provide 1:1 monitoring every shift." A Quarterly Minimum Data Set (MDS) assessment dated 03/04/24 revealed the resident had a Brief Interview for Mental Status (BIMS) summary score of "15" indicating that had an intact cognitive function. Also, the resident was coded for physical behavioral symptoms (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) directed towards others, verbal behavioral symptoms (e.g., threatening others, screaming at others, cursing at others) directed towards others, rejection of care behaviors, and receiving antipsychotic medications on a routine basis. A physician ' s order dated 05/01/24 directed, "Psych consult for aggressive behavior." A care plan dated 05/02/24, documented in part," Focus- Alleged physical aggression towards another resident while both residents were on LOA (leave of absence) on 05/01/24 ... Interventions- continue with 1:1 monitoring ...psych[iatric] consult to evaluate ..."	F 600		

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F 600	Continued From page 14 A Psychiatric Mental Health Nurse Practitioner (PMHNP) note dated 05/03/24 at 2:01 PM documented, "Date of Service: 5/3/24, Consultation Alleged Physical Aggression/Assault to Another Resident. The patient was seen in his room, 1:1 monitoring staff sitting by the door. He stated, "While I was on LOA, I saw her (The alleged victim) at the bus stop and both of us were talking, and this led to a heated argument, and she started yelling and cursing me out and I cursed her out as well. I never touched her, she told me that she is going to teach me a lesson, and they [the facility ' s staff] called the police, and I was arrested." A care plan dated 05/16/24 documented in part, "Focus- verbal aggression towards nursing staff, going around nursing station, attempted to pick up the hole puncher ...Interventions - continue with 1:1 monitoring, staff de-escalated the situation ..." A PMHNP note dated 05/17/24 at 11:14 AM documented, "Date of Service: 5/16/24: Consultation Alleged Verbal Altercation Aggression/Outburst, attempt to hit a facility staff and exposure/fondling his [male genitalia] sitting on the floor in the room. - The patient was seen in his room, 1:1 monitoring staff sitting by the door. He stated, I was standing by the door of my room and the staff came and was trying to force herself into my room and I told her she could not come in and she forced herself through anyway and went to my bathroom to check if I was smoking in the bathroom and she found nothing. I cursed her out because she was not listening and she should not have come into my room for any reason, I don't like her. He denied any attempt to hit the staff.	F 600		

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F 600	Continued From page 15 The provider further asked him about being naked, sitting on the floor, and fondling his [male genitalia]. He stated I was in my room I took the diaper off because my [gonads] feel hot sometimes and I was not fondling with my [male genitalia]. He further endorsed sitting on the floor." Sequence of events: An Admission Summary for Resident #2 dated 06/06/24 at 10:37 PM documented: "[Resident #2] readmitted [to unit 2 south, room 220, bed A] today from [Psychiatric Hospital Name]. Resident came into the facility ambulating at about 3:45 PM with his personal belongings. Resident refused complete physical assessment and skin assessment, refused weight and inventory of his personal belongings on admission. A care plan for Resident #2 dated 06/06/24 documented but not limited to, "Focus - [Resident #2] had an episode of physical aggression towards another resident on 10/01/23. [Resident #2] had an additional episode of physical aggression against another resident on 03/04/24 ...Interventions - hourly monitoring for 72 hours." Review of unit 2 south's "Hourly Monitoring" binder showed no documented evidence that Resident #2 was being monitored hourly from 06/06/24 to 06/09/24. A Nursing Progress Note for Resident #2 dated 06/08/24 at 10:57 PM documented, "Resident to Resident Altercation: At about 6:45 pm a report was received from staff stating that this resident	F 600		

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F 600	Continued From page 16 [Resident #2] was actively having a physical altercation with another resident [Resident #1]. When this writer arrived at the unit, [Resident #2] was observed in the hallway trying to go after [Resident #1] and a staff member was in front of him trying to talk him down from moving forward. At some point, the staff talked him down, and he went back to his room and closed the door. DC (District of Columbia) Metropolitan Police were called at 6:50 pm and the police, including EMS (emergency medical services), arrived at the unit at about 6:55 pm and [Resident #2] was in his room with the door closed. Police knocked at the door and brought [Resident #2] into the hallway and interviewed both residents separately. Resident (#2) was noted bleeding from his left leg but was unsure of where the bleeding was coming from. When paramedics found where the bleeding was coming from, he was quickly 6 transported to [Hospital Name] for evaluation and treatment ..." A Facility Reported Incident (FRI) for Resident #1, DC~12873, submitted to the State Agency on 06/08/24 documented, "There was a physical altercation between [Resident #1] and [Resident #2]. DC Metropolitan police were called. [Resident #2] was taken to the hospital while [Resident #1] was arrested. Investigation was initiated." A FRI for Resident #2, DC~12874, submitted to the State Agency on 06/08/24 documented, "There was a physical altercation between [Resident #1] and [Resident #2]. DC Metropolitan police were called. [Resident #2] was taken to the hospital while [Resident #1] was arrested. Investigation was initiated."	F 600		

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F 600	Continued From page 17 A Hospital Discharge Summary for Resident #2 dated 06/08/24 documented: "Seen today for stab wound of leg, laceration." A Nursing Note for Resident #2 dated 06/09/24 at 1:45 AM documented, "Received a call from [Hospital Name] at 8:45 PM and was informed that the resident has 3 stiches underneath his left knee. At about 10:50 PM, the resident was brought in via stretcher. Resident refused nursing assessment." During a face-to-face interview on 06/12/24 at 2:50 PM, Employee #4 (PMHNP) stated that she has been providing psych services to Resident #1 monthly and as needed (after altercations). Resident #1 was on 1:1 for behavior issues and was not safe to be roommates with another resident who had behaviors issues. On 06/06/24, she came to assess Resident #2 in room 220 A and saw that his roommate was Resident #1. She had safety concerns about Resident #1 and #2 being roommates. After evaluating Resident #2, she asked [Employee #7/ Unit 2 South's Unit Manager] why those two residents were put in the room. At which time, the unit manager informed her that she had nothing to do with the resident ' s room assignment, that decision was made by the Administration. During a face-to-face interview on 06/12/24 at 3:40 PM, Employee #8 (External Marketing Liaison/Admissions Department) stated that she was not a nurse, nor did she have a clinical background. She has been covering for the Admission's Director for the last 3 to 4 months. The resident ' s placement to a room is based on the facility ' s availability of beds and on clinical	F 600		

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F 600	Continued From page 18 compatibility, such as isolation. She makes the determination of the resident's room placement. This was the first time that she was not a part of a resident's admission. However, she was aware that the Administrator and DON were discussing Resident #2's return to the facility. On 06/06/24, the facility had two male beds available. During a face-to-face interview on 06/13/24 at 9:45 AM, Employee #5 (CNA) stated that around 6:45 PM, during dinner, he was in another room when he heard a staff member yelling for help. He ran towards the screams for help and when he got to room 220, he saw that Residents #1 and #2 were fighting. He saw Resident #2 with a meal tray in his hand, hitting Resident #1 over the head three times then the meal tray broke into two pieces. He got in the middle of them, and the other staff pulled Resident #1 to the nurse ' s station. Resident #2 went back inside the room and then came out of the room holding a knife in his right hand and one of Resident #1 ' s shoes. Resident #2 held the show up against the wall and stabbed it until in tore into shredded pieces and fell on the floor. Resident #2 went back into the room and blocked anyone from being able to enter. The police came and were able to enter the room after multiple attempts, talked to Resident #2, and found a knife. During a telephone interview on 06/13/24 at 10:54 AM, Employee #6 (assigned 1:1 CNA) stated that Resident #2 was observed laying in his bed, when Resident #1 returned from LOA. She was sitting outside the room, with the door cracked and could only visualize the upper part of Resident #2 ' s body. The room was quiet until	F 600		

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screaming was heard coming from Resident #2 who yelled out, "Leave me alone! Leave me alone!" She pushed the door open and saw Resident #1 standing over Resident #2 (who was in bed) holding a knife with a black handle. She called for help, when the other staff came, Resident #2 pushed Resident #1 out the room, into the hallway, and closed the door. Resident #1 opened the door and spat on Resident #2. Resident #2 then came out of the room with a meal tray, hitting Resident #1 over the head three times. A male CNA (Employee #5) came and separated the two residents. She helped escort Resident #1 to the nurse ' s station. Employee #5 stayed with Resident #2 until the police arrived.

During a face-to-face interview on 06/13/24 at 11:49 AM, Employee #7 (Unit 2 South's Unit Manager) stated that Employee #3 (DON) spoke with her on 06/06/24 about Resident #1 and Resident #2 not being compatible roommates due to both of their history of physically aggressive behaviors. She also had the same concern, that she brought to the DON's attention during the daily afternoon clinical administration meeting (stand-down) on 06/06/24 and during the daily administrative morning meeting (stand-up) on 06/07/24. However, she was informed by the DON that room 220 bed A was the only bed available in the facility to admit Resident #2.

During a face-to-face interview on 06/13/24 at 5:17 PM, Employee #3 (Director of Nursing/DON) stated that Resident #1 has behavior problems, indecent exposure issues, and can be violent with staff and residents. Resident #1 has attacked him before with his power. He said that Resident #2 resided was on unit 3 south. The resident was territorial and didn't want anyone coming into his

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F 600	Continued From page 20 space. He had a roommate initially, but we never put anyone else in the room with him after the last roommate was discharged. Resident #2 had not had a roommate since I came back to work in June 2023. Facility staff couldn't even get into the room to get it ready for another admission. - Resident #2 did have a physical altercation with another resident which led to Resident #2 being FD12 by the facility ' s psychiatric team on 03/05/24. He was admitted to a local psychiatric hospital from 03/06/24 until 06/06/24 (90 days). According to Employee #3, the facility was unaware that the resident was returning to the facility on 06/06/24. Resident #2 showed up to the facility lobby, getting out of a taxi. Earlier that same day, however, he, the Administrator, Department of Behavioral Health, the Ombudsman, and a representative from a local psychiatric hospital had a telephone conversation discussing Resident #2's return to the facility. The Psychiatric hospital personnel said the resident was stable to return. Employee #3 admitted that he questioned the resident's return after 90 days since the local psychiatric hospital didn't discuss the resident's medical management or provide any clinical background during his 90-day treatment course while at the psychiatric hospital. Employee #2 further stated that he received information about available beds from the Admissions Department. He was informed by the Admissions Department that room 220 bed A was available. The employee also stated that he did not think room 220 bed A was suitable for Resident #2 because of Resident #1's (room 220 bed B) unpredictable behaviors. However, he said he was temporarily placing Resident #2 in that room until he was able to find another room. Additionally, he informed the Administrator of his concerns.	F 600		

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F 600	Continued From page 21 A review of the facility's resident census report dated 06/05/24 and 06/06/24 showed that room 260 bed B was available at the time of Resident #2's admission. However, Employee #3 stated that the Admissions Department did not make him aware that room 220 bed B was available, and that room would have been a better fit for Resident #1. Based on these findings, June 18, 2024, at 10:31 AM an Immediate Jeopardy (IJ) situation was identified. On June 18, 2024, at 5:45 PM, the facility's Administrator provided a corrective action plan to the State Agency Survey Team that was accepted. The plan included: The Administrator or designee immediately ensured the safety and well-being of the resident(s) by the following: - Resident (1) was taken into police custody on 6/8/2024; still in police custody - Resident (2) was sent to ER for medical evaluation for bleeding from the left leg on 6/8/2024. Resident (2) returned to room 220A around 10:45 p.m. on 6/8/2024 with sutures to the left leg. - Resident (2) was placed on hourly monitoring upon return from ER; to be re evaluated on 6/18/2024. Resident (2) will remain in 220 without a roommate and re evaluated every 90 days. - Resident (2) was offered emotional and psych support by social services and Arising Psych Services on 6/10/2024. Resident declined both services. Care plan for refusals of care was revised on 6/14/2024 to include the resident's	F 600		

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F 600	Continued From page 22 refusal of those services. Pysch services will continue monthly and as needed. - The Administrator/designee reviewed and revised the current process for bed assignments for new admissions, readmissions and room relocations in order to protect residents from potential abuse on 6/18/2024. The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 6/19/24) - Administrator, Assistant Administrator, DON, ADON, Unit Managers, Nursing Supervisors, Social Services and Guest Services will be educated by Regional Clinical Consultant/Designee on resident compatibility/agreement, to include documented aggressive behaviors, to ensure that room placements are appropriate and residents are protected from physical, psychosocial harm as well as additional abuse. New Admissions personnel will be educated on resident compatibility/agreement during orientation. - The Administrator/designee will conduct a review of current residents to determine if there are any documented complaints or grievances within the last 30 days related to roommate combability/agreement. Alternative options within residents rights, as related to F559, will be offered. - New, readmissions and current residents will be reviewed by Unit Manager's/Designee for compatibility/agreement, with considerations from F559, daily x5 then weekly x 4 then monthly x 4 or until compliance is sustained. - The Regional Director of Operations will visit the facility 6/19/2024 to provide oversight and	F 600		

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F 600	Continued From page 23 additional training to Administration and Nursing Leadership based on compatibility/agreement audit findings. Corrective action completion date: 6/19/24 2. Facility staff failed to ensure Resident #4 was free from physical abuse by Employee #9. Resident #4 was admitted to the facility on 03/13/18 with multiple diagnoses including Left Side Hemiplegia and Hemiparesis following Cerebral Infarction, Muscle Weakness, Major Depressive Disorder, Restlessness and Agitation, Brief Psychotic Disorder, and Schizoaffective Disorder. A care plan revised on 03/14/24 documented in part, "Focus- [Resident #4] was allegedly throwing stuff at another resident on 03/13/24 during a verbal interaction with another resident. Goal- [Resident #4] will have no episode of physical interaction towards another resident through the next review date x 90 days. Interventions- [Resident #4] was educated to report problems to staff instead of taking [matters] into his own hands. He verbalized understanding. Psych[iatric] consult to evaluate aggressive behavior. Referred to group therapy for coping skills ..." A care plan revised on 04/02/24 documented in part, Focus- [Resident #4] has a behavior problem r/t (related to) cursing, yelling and using profane language on staff and residents, physically abusive to staff ...Interventions: Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and	F 600		

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F 600	Continued From page 24 document. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Psychiatric/Psychogeriatric consult as indicated. When [Resident #4] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later ..." A Quarterly Minimum Data Set (MDS) dated 04/22/24 documented in part, the resident had a Brief Interview for Mental Status summary score of "06" indicating the resident was had severely impaired cognitive status. The resident was also coded for: verbal behavioral symptoms directed towards others (threatening others, screaming at others, and curing at others), rejection of care, and taking antipsychotic medications. A nursing supervisor nursing note dated 06/15/24 at 1PM documented, "Late Entry: Note Text: The resident, [Resident #4] reported that his assigned CNA [Employee #4] had brought him a cup of Lemonade juice and try to take the other cup of juice that was on his table. [Resident #4] said "leave it alone I just got that juice" the staff said she left the cup of juice and on her attempting to leave the room, [Resident #4] picked one of the cup of juice and threw it at her. The CNA turned around as [Resident #4] was attempting to throw the second cup of juice, and she grabbed the cup of juice from him and threw it on him. DC Metropolitan police was called and [officer's name and badge #] and [officer's name and badge]	F 600		

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F 600	Continued From page 25 came to the facility at 12:35pm. Spoke to the staff ... The police then said we should follow through with the facility policy. [Primary Medical Doctor/PMD] notified. Resident refused assessment and vital signs from writer nor his nurse. Resident's guardian [guardian's name] made aware. Will continue to encourage and redirect resident to report any concerns to the supervisor or his nurse." A FRI, DC~12888, received by the State Agency on 06/17/24 at 9:01 AM documented in part, "[Resident #4] ...reported that [Employe #8, CNA] hit me on my forehead and scratched me in the process. She had on rings on her hands. She threw a cup of ice with juice on me. The investigation is still in progress ..." An observation on 06/17/24 at approximately 11:20 AM revealed Resident #4 sitting in his room in his motorized wheelchair. He was alert, dressed, wearing glasses, and was able to understand his name, the time, the place, and the situation. He had left side hemiplegia and a left above-the-knee amputation. Additionally, the resident had three small scratches and redness on his forehead. At the time of the observation, he stated that Employee #9 (assigned CNA) hit him in the face and his glasses came off during their altercation on 06/15/24. He also claimed that the employee was wearing rings at the time, and they may have scratched his skin during the altercation. In the resident's account, the altercation began when Employee #4 was passing water and ice outside his room door. When he asked her to move, she cursed out and became upset. In addition, she threw lemonade and juice at him. However, he denied hitting	F 600		

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F 600	Continued From page 26 Employee #9 or throwing lemonade at her. During a face-to-face interview on 06/17/24 at 5:10 PM, Employee #10 (assigned LPN) reported seeing Employee #9 (assigned CNA) at the resident's door. She heard Employee #9 say stop throwing ice on me. On the floor of the resident's room, she observed ice and water. Further, she noticed scratches on the resident's forehead that weren't there at the start of her shift. He refused to talk to her or allow her to assess him. During a face-to-face interview on 06/18/24 at 8:15 AM, Employee #11 (RN/Supervisor) stated that Employee #9 (assigned CNA) admitted to throwing water and lemonade at Resident #4 after the resident attempted to throw a second cup of lemonade and ice at her. When he observed the resident, he noticed the resident had scratches on his forehead and his shirt was wet. Additionally, the resident was upset and cursing. The resident was also unwilling to talk or be assessed. Following the incident, the resident left the floor and was unavailable to speak with police. During a telephone interview on 06/18/24 at 1:13 PM, Employee #9 (assigned CNA involved in the incident) stated that Resident #4 became upset when she tried to give him a second cup of lemonade with ice. She placed the lemonade on his table in front of him and said I just came to give you a cup of juice. When she was leaving the room, the resident threw a cup of lemonade at her. As she turned around, she noticed that he was attempting to throw a second cup of juice, so she grabbed a cup of lemonade off her cart and threw it at the resident. She believes it may have hit the resident in the face. However, as far as	F 600		

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F 600	Continued From page 27 she could recall, neither she nor the resident hit one another, and she did not notice scratches on the resident's forehead. Additionally, she said she had attended many in-services related to managing residents with challenging behaviors, and she had learned to leave the room when an altercation or incident occurred and report it to a nurse or supervisor.	F 600		
F 693 SS=D	Cross Reference 22B DCMR Sec. 3269.1l Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for	F 693		

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F 693	Continued From page 28 one (1) of nine (9) sampled residents, the facility failed to ensure that Resident #8 received appropriate treatment, services, care and management related to complications (clog) of his enteral feeding tube. The findings included: According to the National Institute of Health (NIH) - Gastrostomy tube (G-tube) malfunction is commonly encountered by nurses, physician assistants, nurse practitioners, and physicians in clinical practice. The team should have a working knowledge of how to handle G-tube problems and provide appropriate intervention and assistance in resolving the dysfunction. https://www.ncbi.nlm.nih.gov/books/NBK482422/ According to the Gastrointestinal Endoscopy Journal: - A common post Percutaneous Endoscopy Gastrostomy (PEG) complication is a clogged tube. - Occasionally, a clogged PEG tube can be opened with the administration of warm water, a canned carbonated beverage, or pancreatic enzymes. - We do not recommend the use of wires or brushes because these instruments, when used blindly, can injure the posterior wall of the stomach. - Once a PEG tube becomes clogged, the best option is replacement. https://www.giejournal.org/article/S0016-5107(06)02538-7/fulltext#:~:text=In%20our%20experience%2C%20once%20a%20PEG%20tube,PEG%20tube%20is%20replaced%20for%20this%20reason	F 693		

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F 693	Continued From page 29 %2C Resident #8 was admitted to the facility on 09/29/22 with multiple diagnoses that included: Gastrostomy Status, Type 2 Diabetes Mellitus, Cerebral Infarction, and Dementia. Review of the resident's medical record revealed the following: A physician's orders dated 01/10/24 that directed, "Enteral feed, every shift, check feeding tube placement with auscultation Q (every) shift and as needed before feedings, flushes, and medication administration." A Quarterly Minimum Data Set (MDS) assessment dated 04/05/24 showed that facility staff coded: severely impaired cognitive skills for decision making; totally dependent on staff for assistance with eating; and received nutrition via a feeding tube. A physician's order dated 04/08/24 that directed, "Enteral feed one time a day, Jevity 1.5 via PEG (Percutaneous Endoscopy Gastrostomy) at 85 ml (milliliters)/hr (hour) to provide 1530 total volume, 2295 kcal (kilocalories), 98 gm (grams) protein & 1162 ml (milliliters) free water, up at 6 PM, down when total volume infused ..." A care plan focus area: "[Resident #8] nutritional r/t (related to) TF (tube feeding) as sole nutrition source" last reviewed on 05/10/24 had interventions that included: "Check for tube placement and gastric contents/residual volume per facility protocol and record; make recommendations for changes to tube feeding as needed; discuss with [Resident	F 693	F693 **1.Corrective Action** Resident #8 was transferred to the hospital on 6/18/24 for Gtube replacement and returned on 6/21/24. Resident #8 remains in the facility with no ill effects. Employee #12 received education on 7/03/2024 on care and treatment of feeding tubes. Employee #12 was assessed for competency on 7/24/2024. **2.Identifying Other Residents** Residents with enteral feeding tubes are at risk of being affected by incorrect tube feeding management. All current eternal feeding tubes will be assessed by Unit Managers/Designee to ensure they are functioning. Malfunctions, such as clogging will be addressed by the licensed nurse immediately. **3.Systemic Change** Staff Educators/Designee will provide education to licensed nurses on care and treatment of feeding tubes. **4.Monitoring Corrective Action** Unit Manager/Designee will audit residents with eternal feeding tubes weekly x3 months. Deficient findings will be addressed immediately. Findings will be reported to QAPI monthly x3 months for review and recommendations to maintain substantial compliance.	7/29/2024

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F 693	Continued From page 30 #8]/family/caregivers any concerns about tube feeding; monitor/document/report to MD (medical doctor) PRN (as needed) - tube dislodged, tube dysfunction or malfunction." A Nursing Progress Note dated 06/16/24 at 7:28 AM documented: - G (gastrostomy)-tube feeding: Jevity 1.5 and water flushes currently in progress and being well tolerated. A Nursing Progress Note dated 06/16/24 at 12:27 PM documented: - PEG Tube: Resident tolerated all due med via patent peg tube, no nausea or vomiting. A physician's order dated 06/16/24 that directed, "GI (gastrointestinal) consult for evaluation of peg tube placement." A Nursing Progress Note dated 06/17/24 at 7:58 AM documented: - G-tube feeding: Resident remains stable and alert. - Jevity 1.5 and water flushes are currently in progress and being well tolerated. A Nursing Progress Note dated 06/17/24 at 1:11 PM documented, "Peg Tube: resident tolerated all due med (medications) via patent peg tube, no nausea or vomiting, turn and position Q (every) 2 hours, incontinent care given as needed. No non-verbal signs of pain. Scopolamine patch replaced, resident resting comfortable." A Nursing Progress Note dated 6/17/24 at 11:50 PM documented: - PEG Tube: resident is stable, G tube in place and patent, feeding continues with Jevity 1.5 at	F 693		

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F 693	Continued From page 31 85cc (milliliters)/hr, water flushes of 300cc q (every) 4 hrs (hours), up time at 6:00 PM. A Nursing Progress Note dated 06/18/24 at 7:12 AM documented: - Jevity 1.5 and water flushes are currently in progress and being well tolerated. A Nursing Progress Note dated 06/18/24 at 2:17 PM documented, "ER (emergency room) transfer: Resident given order to transfer to closest ER for Peg tube replacement, RP [Representative's name] was called but was not reached, message left to call facility." A Nursing Progress Note dated 06/18/24 at 2:27 PM documented: - PEG Tube: Resident tolerated all due med via patent peg tube, no signs of distress noted. A Nursing Progress Note dated 06/18/24 at 3:50 PM documented, "Transportation was arranged, pick up time between 4 and 5 'clock. Next shift will follow up." A Nursing Progress Note dated 06/18/24 at 8:56 PM documented, " ...Received report from day shift nurse that DNP (Doctor of Nurse Practitioner) gave order to transfer resident to ER for PEG tube replacement - malfunction ... ambulance came at 3:55 PM and left with resident at 4:10 PM. RP was notified ..." A Situation Background Assessment Request (SBAR) Communication Tool dated 06/18/24 at 9:06 PM documented: - Situation: PEG tube malfunction - [RP's name] contacted on 06/18/24 at 4:45 PM by phone; [DNP's name] contacted at 2:30 PM.	F 693		

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F 693	Continued From page 32 - Resident was sent to [Hospital name], report given to [ER nurse] at 5: 00 PM. A Nursing Progress Note dated 06/18/24 at 11:06 PM documented: - The writer called [Hospital name] ER to F/U (follow/up) on resident's status; was informed that resident is admitted due to PEG tube dysfunction. - DNP made aware. RP was called but did not pick up, message was left to call back the unit. A Complaint, DC~12902, received by the State Agency on 06/20/24 documented: - On Tuesday, 06/18/24, the G-Tube was cut very short, clogged, and sent to the hospital for replacement. Review of the facility's resident census and a tour of unit 3 north on 06/20/24 at 1:20 PM, Resident #8 was noted to be out of the facility and on hospital leave. The nursing assignment for unit 3 north showed that Employee #12 (Registered Nurse/RN) was assigned to Resident #8 on the day shift (7:00 AM - 3:00 PM) on 06/16/24, 06/17/24 and on 06/18/24. During a face-to-face interview on 06/20/24 at 1:22 PM, Employee #13 (Registered Nurse/RN) stated, "She (Employee #12/RN) came to me (on 06/16/24, day shift) and told me that the resident's (Resident #8) g -tube was clogged and that she couldn't unclog it. His tube was really long and the DeClogger (device used achieve patency of gastric tubes) was not long enough and could not reach where the clog was. We then tried using a syringe of water to flush it and that's when the G - tube burst. [Employee #12] cut the	F 693		

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F 693	Continued From page 33 tube below where it burst and where the clog was. The tube flushed after that, and she (Employee #12) attached the resident's feeding back." During a telephone interview on 06/20/24 at 1:57 PM, Employee #12 (RN) stated, "When I took over the shift on Sunday morning (06/16/24, day shift) I went to flush it (Resident #8's G-tube) and it did not flush. Myself and a colleague (Employee #13) tried for an hour to unclog the tube. Then all of a sudden, water started spewing out of the tube, indicating there was a hole. The G -tube was long so using scissors, I cut below where the hole was. After cutting it (the G- tube), the tube worked just fine, it flushed, and I administered [Resident #8's] medications and feeding. I called the MD, and she gave an order for a GI consult to send the patient to the ER after I let her (MD) know that the G-tube malfunctioned." When asked where she documented that there were issues with Resident #8's G-tube and that she had informed the MD, Employee #12 stated, "I did not document that the G-tube had malfunctioned or that I had cut it." The employee was further asked if cutting a resident's G-tube was the standard of practice for managing a malfunction, Employee #12 stated, "No." The evidence showed that Resident #8's G-tube had malfunctioned on 06/16/24 at approximately 8:00 AM and Employee #12 (assigned RN) failed to document the malfunction (tube being clogged then bursting, then being cut by staff). Resident #8 was not sent to the ER until 06/18/24, at approximately 4:00 PM (56 hours later), to get his G-tube replaced. During a face-to-face interview on 06/20/24 at	F 693		

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F 693	Continued From page 34 3:30 PM, Employee #14 (Assistant Director of Nursing/ADON) stated, "Cutting a resident's G-tube is absolutely not our process for managing a clog or any other issues. I was not aware that was what happened. The documentation said "malfunction" on 06/18/24 and he was sent to the ER. There was no documentation prior to 06/18/24 to indicate that there had been anything wrong with [Resident #8's] tube. The resident should have been sent out to the ER immediately on that day (06/16/24) for replacement of his G-tube. We will be providing education to all the licensed nursing staff on the process and protocols for managing a G-tube."	F 693		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		

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F 726	Continued From page 35 implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (1) of nine (9) sampled residents, the licensed nursing staff failed to demonstrate the appropriate competencies and skill sets to provide nursing services to assure resident safety and well-being of each resident. Resident #8. The findings included: According to the National Institute of Health (NIH) - Gastrostomy tube (G-tube) malfunction is commonly encountered by nurses, physician assistants, nurse practitioners, and physicians in clinical practice. The team should have a working knowledge of how to handle G-tube problems and provide appropriate intervention and assistance in resolving the dysfunction. https://www.ncbi.nlm.nih.gov/books/NBK482422/ According to the Gastrointestinal Endoscopy Journal: - A common post Percutaneous Endoscopy Gastrostomy (PEG) complication is a clogged tube. - Occasionally, a clogged PEG tube can be opened with the administration of warm water, a canned carbonated beverage, or pancreatic	F 726	F726 **1.Corrective Action** Resident #8 was transferred to the hospital on 6/18/24 for Gtube replacement and returned on 6/21/24. Resident remains in the facility with no ill effects. Employee #12 received education on 7/03/2024 on care and treatment of feeding tubes. Employee #12 was assessed for competency on 7/24/2024. **2.Identifying Other Residents** Residents with enteral feeding tubes are at risk of being affected by incorrect tube feeding management. Current eternal feeding tubes will be assessed by Unit Managers/Designee to ensure they are functioning. Malfunctions, such as clogging will be addressed by the licensed nurse immediately. **3.Systematic Change** Unit manager/designee will randomly observe licensed nurses provide randomly observe care for eternal feeding tubes weeklyx3 months. Findings will be addressed immediately. Staff Educators/ Designee will provide education to licensed nurses on care and treatment of feeding tubes. **4.Monitoring Corrective Action** Unit Manager/Designee will audit residents with eternal feeding tubes weekly x3 months. Deficient findings will be addressed immediately. Findings will be reported to QAPI monthly x3 months for review and recommendations to maintain substantial compliance.	7/29/2024

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	095022	A. BUILDING _____ B. WING _____	C 06/20/2024

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F 726	Continued From page 36 enzymes. - We do not recommend the use of wires or brushes because these instruments, when used blindly, can injure the posterior wall of the stomach. - Once a PEG tube becomes clogged, the best option is replacement. https://www.giejournal.org/article/S0016-5107(06)02538-7/fulltext#:~:text=In%20our%20experience%2C%20once%20a%20PEG%20tube,PEG%20tube%20is%20replaced%20for%20this%20reason%2C Resident #8 was admitted to the facility on 09/29/22 with multiple diagnoses that included: Gastrostomy Status, Type 2 Diabetes Mellitus, Cerebral Infarction, and Dementia. Review of the resident's medical record revealed the following: A physician's orders dated 01/10/24 that directed, "Enteral feed, every shift, check feeding tube placement with auscultation Q (every) shift and as needed before feedings, flushes, and medication administration." A Quarterly Minimum Data Set (MDS) assessment dated 04/05/24 showed that facility staff coded: severely impaired cognitive skills for decision making; totally dependent on staff for assistance with eating; and received nutrition via a feeding tube. A physician's order dated 04/08/24 that directed, "Enteral feed one time a day, Jevity 1.5 via PEG (Percutaneous Endoscopy Gastrostomy) at 85 ml (milliliters)/hr (hour) to provide 1530 total volume,	F 726		

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F 726	Continued From page 37 2295 kcal (kilocalories), 98 gm (grams) protein & 1162 ml (milliliters) free water, up at 6 PM, down when total volume infused ..." A care plan focus area: "[Resident #8] nutritional r/t (related to) TF (tube feeding) as sole nutrition source" last reviewed on 05/10/24 had interventions that included: "Check for tube placement and gastric contents/residual volume per facility protocol and record; make recommendations for changes to tube feeding as needed; discuss with [Resident #8]/family/caregivers any concerns about tube feeding; monitor/document/report to MD (medical doctor) PRN (as needed) - tube dislodged, tube dysfunction or malfunction." A Nursing Progress Note dated 06/16/24 at 7:28 AM documented: - G (gastrostomy)-tube feeding: Jevity 1.5 and water flushes currently in progress and being well tolerated. A Nursing Progress Note dated 06/16/24 at 12:27 PM documented: - PEG Tube: Resident tolerated all due med via patent peg tube, no nausea or vomiting. A physician's order dated 06/16/24 that directed, "GI (gastrointestinal) consult for evaluation of peg tube placement." A Nursing Progress Note dated 06/17/24 at 7:58 AM documented: - G-tube feeding: Resident remains stable and alert. - Jevity 1.5 and water flushes are currently in progress and being well tolerated.	F 726		

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F 726	Continued From page 38 A Nursing Progress Note dated 06/17/24 at 1:11 PM documented, "Peg Tube: resident tolerated all due med (medications) via patent peg tube, no nausea or vomiting, turn and position Q (every) 2 hours, incontinent care given as needed. No non-verbal signs of pain. Scopolamine patch replaced, resident resting comfortable." A Nursing Progress Note dated 6/17/24 at 11:50 PM documented: - PEG Tube: resident is stable, G tube in place and patent, feeding continues with Jevity 1.5 at 85cc (milliliters)/hr, water flushes of 300cc q (every) 4 hrs (hours), up time at 6:00 PM. A Nursing Progress Note dated 06/18/24 at 7:12 AM documented: - Jevity 1.5 and water flushes are currently in progress and being well tolerated. A Nursing Progress Note dated 06/18/24 at 2:17 PM documented, "ER (emergency room) transfer: Resident given order to transfer to closest ER for Peg tube replacement, RP [Representative's name] was called but was not reached, message left to call facility." A Nursing Progress Note dated 06/18/24 at 2:27 PM documented: - PEG Tube: Resident tolerated all due med via patent peg tube, no signs of distress noted. A Nursing Progress Note dated 06/18/24 at 3:50 PM documented, "Transportation was arranged, pick up time between 4 and 5 'clock. Next shift will follow up." A Nursing Progress Note dated 06/18/24 at 8:56 PM documented, " ...Received report from day	F 726		

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F 726	Continued From page 39 shift nurse that DNP (Doctor of Nurse Practitioner) gave order to transfer resident to ER for PEG tube replacement - malfunction ... ambulance came at 3:55 PM and left with resident at 4:10 PM. RP was notified ..." A Situation Background Assessment Request (SBAR) Communication Tool dated 06/18/24 at 9:06 PM documented: - Situation: PEG tube malfunction - [RP's name] contacted on 06/18/24 at 4:45 PM by phone; [DNP's name] contacted at 2:30 PM. - Resident was sent to [Hospital name], report given to [ER nurse] at 5: 00 PM. A Nursing Progress Note dated 06/18/24 at 11:06 PM documented: - The writer called [Hospital name] ER to F/U (follow/up) on resident's status; was informed that resident is admitted due to PEG tube dysfunction. - DNP made aware. RP was called but did not pick up, message was left to call back the unit. A Complaint, DC~12902, received by the State Agency on 06/20/24 documented: - On Tuesday, 06/18/24, the G-Tube was cut very short, clogged, and sent to the hospital for replacement. Review of the facility's resident census and a tour of unit 3 north on 06/20/24 at 1:20 PM, Resident #8 was noted to be out of the facility and on hospital leave. The nursing assignment for unit 3 north showed that Employee #12 (Registered Nurse/RN) was assigned to Resident #8 on the day shift (7:00 AM - 3:00 PM) on 06/16/24, 06/17/24 and on 06/18/24.	F 726		

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F 726	Continued From page 40 During a face-to-face interview on 06/20/24 at 1:22 PM, Employee #13 (Registered Nurse/RN) stated, "She (Employee #12/RN) came to me (on 06/16/24, day shift) and told me that the resident's (Resident #8) g -tube was clogged and that she couldn't unclog it. His tube was really long and the DeClogger (device used achieve patency of gastric tubes) was not long enough and could not reach where the clog was. We then tried using a syringe of water to flush it and that's when the G - tube burst. [Employee #12] cut the tube below where it burst and where the clog was. The tube flushed after that, and she (Employee #12) attached the resident's feeding back." During a telephone interview on 06/20/24 at 1:57 PM, Employee #12 (RN) stated, "When I took over the shift on Sunday morning (06/16/24, day shift) I went to flush it (Resident #8's G-tube) and it did not flush. Myself and a colleague (Employee #13) tried for an hour to unclog the tube. Then all of a sudden, water started spewing out of the tube, indicating there was a hole. The G -tube was long so using scissors, I cut below where the hole was. After cutting it (the G- tube), the tube worked just fine, it flushed, and I administered [Resident #8's] medications and feeding. I called the MD, and she gave an order for a GI consult to send the patient to the ER after I let her (MD) know that the G-tube malfunctioned." When asked where she documented that there were issues with Resident #8's G-tube and that she had informed the MD, Employee #12 stated, "I did not document that the G-tube had malfunctioned or that I had cut it." The employee was further asked if cutting a resident's G-tube was the standard of practice for managing a malfunction,	F 726		

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F 726	Continued From page 41 Employee #12 stated, "No." The evidence showed that Resident #8's G-tube had malfunctioned on 06/16/24 at approximately 8:00 AM and Employee #12 (assigned RN) failed to document the malfunction (tube being clogged then bursting, then being cut by staff). Resident #8 was not sent to the ER until 06/18/24, at approximately 4:00 PM (56 hours later), to get his G-tube replaced. During a face-to-face interview on 06/20/24 at 3:30 PM, Employee #14 (Assistant Director of Nursing/ADON) stated, "Cutting a resident's G-tube is absolutely not our process for managing a clog or any other issues. I was not aware that was what happened. The documentation said "malfunction" on 06/18/24 and he was sent to the ER. There was no documentation prior to 06/18/24 to indicate that there had been anything wrong with [Resident #8's] tube. The resident should have been sent out to the ER immediately on that day (06/16/24) for replacement of his G-tube. We will be providing education to all the licensed nursing staff on the process and protocols for managing a G-tube."	F 726		