STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS On February 10 - 17, 2023, an unannounced complaint survey was initiated at this facility. On February 17, 2023, the survey was converted to a recertification survey after analysis of preliminary findings. The recertification survey continued from February 17, 2023 - March 10, 2023. Survey activities consisted of a review of 105 sampled residents and the census at the start of the survey was 343. The following complaints were investigated during this survey: DC~10495, DC~10617, DC~10688, DC~10691, DC~10723, DC~10822, DC~10877, DC~10886, DC~10887, DC~10966, DC~11325, DC~11450, DC~11451, DC~11471, DC~11479, DC~11521, DC~11549, DC~11567, DC~11687, and DC~11694. The following facility-reported incidents were investigated during this survey: DC~10724, DC~11077, DC~10863, DC~11243, DC~11508, DC~11511, DC~11517, DC~11531, DC~11617, DC~11664, DC~11665, DC~11673, DC~11674, DC~11686, DC~11688, DC~11696, DC~11699 and DC~11739. 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. Substandard quality of care was identified at F760 and the survey team conducted the extended survey from February 24, 2023, to March 10, 2023. In addition, actual harm was identified at F684 for Resident #56, and F600 for Residents #169 and	F 000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that immediate jeopardy exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and immediate jeopardy removal plan. This immediate jeopardy removal plan is submitted as the facility's immediate actionable plan to remove the likelihood that serious harm to a resident will occur or recur.	06/09/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ADMINISTRATOR (X6) DATE 06/08/2023

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 #131. During this survey, an immediate jeopardy (IJ) was identified at 42 CFR §483.15 Admissions, Transfers and Discharge (F624) on February 17, 2023, at 5:08 PM. The facility provided a plan of corrective action to address the identified concerns on February 18, 2023, at 1:07 AM and itwas accepted. After the plan was verified the IJ was removed on February 21, 20,23 at 5:45 PM while the survey team was onsite. During this survey, an immediate jeopardy (IJ) was identified at 42 CFR §483.45 Pharmacy Services (F760) on February 17, 2023, at 5:24 PM. The facility provided a plan of corrective action to address the identified concerns on February 18, 2023, at 2:22 AM and it was accepted. After the plan was verified the IJ was removed on February 22, 2023, at 6:40 PM whilethe survey team was onsite. During this survey, an immediate jeopardy (IJ) was identified at 42 CFR §483.45 Pharmacy Services (F761) on February 17, 2023, at 5:24 PM. The facility provided a plan of corrective action to address the identified concerns on February 18, 2023, at 12:59 AM and it was accepted. After the plan was verified the IJ wasremoved on February 22, 20,23 at 12:40 PM while the survey team was onsite. During this survey, an immediate jeopardy (IJ) was identified at 42 CFR §483.60 Food and Nutrition Services (F803) on February 17, 2023, at 6:04 PM. The facility provided a plan of corrective action to address the identified concerns on February 18, 2023, at 2:30 AM and itwas accepted. After the plan was verified the IJ	F 000		

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F 000	Continued From page 2 was removed on February 22, 2023, at 6:40 PM while the survey team was onsite. The following deficiencies are based on observation, record review, and resident and staffinterviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the 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	F 000		

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F 000	Continued From page 3 IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical NurseL - Liter Lbs. - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) 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 AssociationNP - 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	F 000		

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F 000	Continued From page 4 Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 552	1. R74 was discharged on 03/28/2023. 2.The Director of nursing or designee reviewed the current residents who had orders for Depakote and Exelon patch on 5/11/23 to ensure that the residents' RPs are notified. Findings indicated that several resident's RPs were not notified of Depakote and Exelon orders. All issues were corrected. 3.Residents who are potentially affected are the residents who are prescribed Exelon and Depakote. The nurse educator or designee initiated in services starting on 5/23/23 for the nursing staff to ensure that residents' RPs are notified of Depakote and Exelon patch orders when there is a significant change in the resident's treatment plan. 4.The Unit manager or designee will audit new orders for Depakote and Exelon patches to ensure that residents' RPs are notified of treatment. Audits will be conducted weekly x4 and monthly x3 until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	06/09/2023
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, andparticipate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his orher total health status, including but not limited to,his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the typeof care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner orprofessional, of the risks and benefits of proposedcare, of treatment and treatment alternatives or treatment options and to choose the alternative oroption he or she prefers. This REQUIREMENT is not met as evidencedby: Based on record review, family interview, andstaff interview, for one (1) of 105 sampled residents, the facility's staff failed to notify a resident's family regarding use of medications(Depakote and Exelon). (Resident #74.) The findings included: Resident #74 was admitted to the facility with multiple diagnoses including Paranoid Schizophrenia, Anxiety and Dementia with other			

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F 552 Continued From page 5
Behavioral Disturbances.

A review of physician orders dated 11/29/22 noted, "Depakote Delayed Released 50 MG (milligrams) - give 1 tablet via g-tube (gastrostomy tube) two times a day for mood disorder."

A review of Medication Administration Records (MAR) dated from 11/29/22 through 02/02/23 revealed the resident was administered Depakote500 mg via G-tube daily from 11/29/22 to 12/31/22 and 01/10/23 to 02/02/23, and the Exelon Patch 24 Hour 4.6 MG/HR, 1 patch transdermally every 24 hours from 11/29/22 to 12/09/22.

A review of an annual Minimum Data Set dated 12/06/22 revealed the resident was coded for "short-term and long-term memory problems, unable to recall the current season, location of room, staff name and faces, or that [pro-noun] was in a nursing home. Also, the resident was coded for receiving anti-anxiety medications."

A review of the resident's medical record including progress notes dated from 11/29/22 to 01/15/23 lacked documented evidence facility's staff made the resident's family (responsible party) that Resident #74 was started on Depakoteand Exelon.

Continued review of physician orders revealed anorder dated 01/10/23 documented, "Depakote Delayed Released 50 MG (milligrams) - give 1 tablet via g-tube two times a day for mood disorder. Exelon Patch 24 Hour 4.6 MG/24 HR - apply 1 patch transdermally every 24 hours for Dementia ..."

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F 552	Continued From page 6 During an on-site compliant investigation on 02/13/23 at approximately 5:00 PM, the daughterof Resident #74 (responsible party) reported during an interview that the facility staff had not informed her that they started Resident #74 on medications Depakote and Exelon. During a face-to-face interview on 02/15/23 at approximately 11:00 AM, Employee #24 (RN/Unit Manager) stated that staff should have documented in the resident's record when familymembers were informed of a new medication.	F 564	1. R60 was provided a zoom call on3/14/23. 2. Resident council meeting will be held on 06/01/2023 to review that residents/representatives will be provided an opportunity to schedule zoom calls for virtual visitation if desired. Robo calls were completed on 5/12/23 to inform residents/representatives of zoom call availability if desired. All Residents have the potential to be affected. 3. Activity/Social work/ Nursing staff will be educated by the Staff Educator/Designee that residents/representatives requesting to have zoom calls for virtual visitation will be provided. During the care conference residents/representatives will be provided with the opportunity for a zoom call if in person visitation is not feasible. 4. Social work/designee will conduct random audits of residents/representatives to assure that zoom calls for virtual visitation are offered if desired. Audits will be conducted weekly x4 and monthly x3. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.	06/09/2023
F 564 SS=D	Inform Visitation Rghts/Equal Visitation Prvl CFR(s): 483.10(f)(4)(vi)(A)-(D) §483.10(f)(4)(vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasonsfor the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to,a spouse (including a same-sex spouse), a domestic partner (including a same-sex domesticpartner), another family member, or a friend, andhis or her right to withdraw or deny such consentat any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual			

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F 564	Continued From page 7 orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidencedby: Based on record review and staff interview, forone (1) of 105 sampled residents, the facility failed to ensure a resident's family was providedinformation to schedule zoom calls for virtual visitation from 11/31/22 to 03/09/23 (Resident #60). The findings included: Resident #60 was re-admitted to the facility on 02/11/22 with multiple diagnoses including Hemiplegia, Cerebral Infarction, and Morbid Obesity. A review of two documents titled "Resident Virtual Visit Schedule" revealed virtual visits were conducted at 11:00 AM on 07/15/22 and 11:00 AM on 11/30/22. The visit on 7/25/22 documentedit was conducted with the complainant, and that they were present. A review of a complaint received by the state agency (DC-11471) on 1/09/23, " ...I live in NorthCarolina and I'm unable to see [pro-noun] on a daily basis, but I used to be able to video chat with [pro-noun] regularly. The last time I saw [pro-noun] on video .... was October 21, 2022, through Skpe [sp]. Every time I call the recreational department to set up a Skype video call, they do not answer the phone, and if they do,they say that they will have to call me back...This has been the case for several months."	F 564		

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F 564	Continued From page 8 During a face-to-face interview on 03/08/23 at 12:34 PM, Employee #56 (Director of Recreation Therapy) stated that the recreation aides in the units were responsible for scheduling remote visits via Zoom. The employee stated that there had not been a recreation aide in the unit where Resident #60 lived for many months. Employee #56 also said she would contact the complainant (responsible party) after this interview to schedulea Zoom meeting as soon as possible.	F 564		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident'spersonal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any comminglingof resident funds with facility funds or with the funds of any person other than another resident.(C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidencedby: Based on observation, record review, resident interview, and staff interview, for one (1) of 19 sampled residents whose personal funds are managed by the facility, the facility's staff failed toadhere to generally accepted accounting principles when acting as a manager (representative payee) for the resident's personalfunds (social security benefits) without the resident's permission (Resident #229).	F 568	1.R229 consented to facility as representative payee for resident personalfunds on 3/7/23. E53 was educated on acceptable accounting principles when acting as a representative payee for resident personalfunds. 2.Residents whose personal funds are managed by the facility will be reviewed starting on 5/18/23 by the Regional Business Office Manager/designee to assure that the facility adheres to acceptable accounting principles when acting as a representative payee for resident personal funds and obtains permission. All Residents who require the facility to be the Rep Payee have the potential to be affected. 3.Business office staff will be educated by Administrator on 5/18/23 to assure that facility adheres to accounting principles when acting as a representative payee for resident personal funds and has resident permission. 4.Administrator/designee will audit 10% of residents whose personal funds are managed by the facility to assure that facility adheres to acceptable accounting principles when acting	6/9/2023

as a representative payee for resident personal funds and obtains permission. Audits will be conducted weekly x4 then monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.

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F 568	Continued From page 9 The findings included: Resident #229 was admitted to the facility on 10/25/22 Chronic Obstructive Pulmonary Disease, Brady Cardia, and Muscle Weakness. A review of Resident #229's electronic medical record revealed a business office general note dated 11/22/22 at 11:57 that documented, "Presented resident with NOMNC (Notice of Medicare Non-Coverage). Explained to the resident how her Medicaid benefits work in LTC (long term care) facility. She stated she does not want her money coming to the facility and refusedto sign the direct deposit form. It was explained to her the facility will apply to be rep [representative] payee ..." A review of a document titled "Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits" dated 11/28/22 revealed the facility's staff answered the questions listed below, as follows: 2. Do you believe the patient is capable of managing or directing the management of benefits in his or own best interest? "No". 3. Do you expect the patient to be able to managefunds in the future (for example the patient is temporarily unconscious)? "No". Further review of the document showed Employee #53 (Business Office Manager) signedas the applicant applying for representative payeefor Resident #229. A review letter for the Social Security Administrator dated 02/16/23 documented, "We	F 568		

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F 568	Continued From page 10	F 568		

are writing you about [Resident's name] Social Security benefits ...as you requested on or about 02/09/23 we changed [Resident's name} direct deposit information. We will send her Social Security payments to the new financial institutionor account you selected ..."

A review of a document titled, "Resident Statement Landscape" showed the facility received Resident #229's social security benefitstwice on 02/07/23 and 03/03/23 after applying forrep-payee status.

During an observation on 03/07/23 at approximately 10:00 AM, Resident #229 was noted to be sitting on the side of the bed, leaningon the bedside table, looking down. When askedif everything was okay, the resident stated, "No, Idon't have any money. They took my money, andI didn't sign papers for them to do that." When asked, who took her check, the resident stated itwas the business office staff.

During a face-to-face interview on 03/07/23 at approximately 1:00 PM, Employee #53 stated, "I explained to the resident on 11/22/22 that if she refused to sign over her [social security] check, I would have to apply for the facility to be rep - payee". When asked, if she had a policy relatedto that practice, she stated, "No, the corporate office told me to do that." When asked, if the facility's Administrator also told her to implementthat practice when applying for rep-payee, she stated, "No".

During a telephone interview on 03/07/23 at 1:20PM, Employee #1 (Administrator) stated, "Underno circumstance should she (Employee #53) apply for rep-payee if the resident refuses for us

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F 568	Continued From page 11 the be rep-payee." Cross reference 22B DCMR sect. 3269.1(c)	F 568		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adultresidents concerning the right to accept or refusemedical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directivesand applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or shehas executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		

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F 578	Continued From page 12 with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once heor she is able to receive such information. Follow-up procedures must be in place to providethe information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidencedby: Based on observation, record review, and staff interviews for 8 of 105 sampled residents, facilitystaff failed to 1. ensure that residents or family members were provided information to formulatean advance directive and 2. ensure that current copies of the advance directives were in the Residents' medical records. (Residents #286, #101, #272, #29, #158, #10, #53, and #247) 1. Resident #286 was admitted to the facility on 10/24/22 with multiple diagnoses that included Paraplegia, Morbid Obesity, Hypertension, Type 2Diabetes, Peripheral Neuropathy and Muscle Weakness. A Quarterly Minimum Data Set (MDS) assessment dated 01/31/2023 documented Resident #286 had a Brief Interview for Mental Status score of "11" indicating the resident had amoderately impaired cognitive status and Functional Status for Activities of Daily Living indicating 2-person physical assistance for bed mobility, transfer, locomotion on and off unit, dressing, toilet use and personal hygiene. Review of Resident #286's medical record on 03/03/23 at 10:00 AM, revealed a blank MOST (Medical Orders for Scope of Treatment) form that stated, "...The MOST does not replace anadvanced directive ...An advance directive is	F 578	1.R158 was discharged from the facility on 4/27/2023. R286, R101, R272, R29, R10, R53, R247 currently reside in the facility and have not suffered any ill effects. Residents/representatives were provided information related to advance directives on the dates that follow: R286 on 5/4/23, R101 5/3/23, R 272 5/4/23, R29 5/8/23, R10 5/4/23, and R53 5/4/23, R 247 5/8/23. All advance directives were placed in the medical record per the dates above and actions were documented in PCC. E26, E27, E28, E29, E30, E18, E14, E51 were educated on requirement to offer residents/representatives information related to advance directive and any copies of advance directives available to be placed in the medical record. 2.Social worker director or designee will review the current residents in the facility to ensure that residents/representatives were provided information to formulate an advance directive, and that current copies of the advance directives are in the residents' medical records. All residents who have not executed an advance directive have the potential to be affected. There were several residents who were not offered the advance directive. All were offered the opportunity to complete the advance directive although two residents declined. 3.The Social worker director or designee will in service the social worker staff to ensure that residents/representatives were provided information to formulate an advance directive, and that current copies of the advance directives are in the residents' medical records. 4. The Social worker director or designee will audit 20% of the facility census to ensure that	06/09/2023

resident/representatives were provided information to formulate an advance directive, and that current copies of the advance directives are in the residents' medical records. Audits will be conducted weekly x4 and monthly x3 until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.

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F 578	Continued From page 13	F 578		

encouraged for all competent adults regardless oftheir health status..."

During a face-to-face interview conducted at the time of the observation on 03/03/23 at 10:16 AM,Employee #26 and Employee #27 acknowledgedthe MOST Form in the resident's record was blank. Employee #26 then stated, "This is supposed to be filled out by the Social Worker after talking with the family, [Resident #286] is a full code though." When asked how someone would know the code status looking at the blank form in the resident's current medical record, Employee #26 replied, "I know because [pronoun]told me." Employee #27 had no comment and stated [pronoun] would "look into it."

During a face-to-face interview on 03/03/23 at 11:08 AM with Resident #286, the resident was asked about receiving an advance directive. Theresident replied "What's that? Can you tell me what that is?" The writer explained to the resident what an advance directive is and the purpose of it and the resident replied, "Oh no, nobody talked to me about that."

During a face-to-face interview on 03/03/23 at 12:08 PM with Employee #28, when asked to confirm where the writer would be able locate theadvance directive in Resident #286's medical record, Employee #28 responded, "Are you looking for the code status?. This is what we sendout for their code status," (pointing to the blank MOST form in the physical chart), "Yes, this is theform, but it's not filled out yet, the SW(Social Workers) usually do it."

During a face-to-face interview on 03/03/23 at 2:48 PM, Employee #29 and Employee #30 were

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F 578	Continued From page 14 shown the blank MOST Form in Resident #286's medical record and asked if they were familiar with that form and why the MOST Form was not completed since the resident's admission 130 days prior to this interview. Employee #30 responded, "My understanding, that it is a MOSTform to be given to the resident" and Employee #29 interjected and stated, "It's a voluntary form offered to them on admission, if have power of attorney, what we offer is both forms, MOST andthe Advance Directive is left with the Resident if they have Responsible Party or guardian will inform them of what it is. We don't go into detail with them we just provide it to them because that's a medical order. We explain we're not Attorney's in event you're deemed incompetent it will be a longer process so best to get this done now; no one in this building is able to sign as a witness, we provide suggestions for a notary." 2. Resident #158 was admitted to the facility on 01/20/23 with multiple diagnoses including Type 2Diabetes Mellitus and Chronic Kidney Disease. A review of an admission Minimum Data Set dated 01/27/23 documented the resident had a Brief Interview for Mental Status summary scoreof "15" indicating the resident had an intact cognitive status. A review of the resident medical record lacked documented evidence that the resident was provided written information regarding the right toformulate an Advanced Directive. An observation on 02/13/23 at approximately 11:00 AM showed the resident was in bed watching television. The resident was asked if thefacility's staff provided [pro-noun] with written	F 578		

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information regarding formulating an Advanced Directive, and the resident stated, "No."

During a face-to-face interview on 02/13/22 at 2:00 PM, Employee #29 (Director of Social Work)gave the surveyor a document titled, "Advance Directives". The employee then stated that the social work department provides all residents witha copy of the document on admission. However, when the surveyor showed the resident the "Advance Directives" document on the same dayat approximately 2:10 PM, the resident stated, "I did not get a copy of this document."

Cross reference 22B DCMR sect. 3231.12(r)

3. Resident #101 was admitted to the facility on 01/29/2016, with multiple diagnoses that included the following: Dementia with Behavioral Disturbance, Alcohol Abuse with Intoxication, andOther Reduced Mobility.

It was noted on Resident #101's face sheet thatthe resident was his own responsible party andthat he is a full code.

A review of the Quarterly Minimum Data Set (MDS) dated 02/08/23 revealed that the facility staff coded that a Brief Interview for Mental statusshould not be conducted, and that the resident had both a short-term and long-term memory problem.

Resident #101's medical record lacked documented evidence that the facility's staff offered the resident an opportunity to formulatean advanced directive.

During a face-to-face interview conducted on

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F 578	Continued From page 16 03/03/23 at 2:50 PM Employee #18 (Unit Manager 3 South) stated that the residents are offered an opportunity to form an advanced directive on admission and that Resident #101 was admitted years ago when another companyowned the facility. 4. Resident #272 was admitted to the facility on 01/22/22 with multiple diagnoses that included the following: Heart Failure, Chronic Atrial Fibrillation, and Sleep Apnea. A review of the medical record revealed a face sheet noting the resident as their own responsibleparty and that they are a full code. A review of the Annual Minimum Data Set (MDS) dated 01/29/23 showed that the facility staff coded the resident as being cognitively intact. Resident #272's medical record lacked documented evidence that the facility's staff offered the resident an opportunity to formulatean advanced directive. During a face-to-face interview conducted on 03/03/23 at approximately 4:00 PM, Employee#14 (unit Manager 3 South) stated that the resident's MOST (Medical Orders for Scope ofTreatment) form in the chart was the advanceddirective. The surveyor showed Employee #14 a notationon the MOST form that indicated it was not an Advanced Directive. 5. Resident #29 was admitted to the facility on 05/03/20 with multiple diagnoses that included Schizophrenia, Acquired Absence of Right Leg	F 578		

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F 578	Continued From page 17 Below Knee, and Acute Kidney Failure. A review of the medical record revealed the resident's face sheet indicated the resident had aresponsible party and the resident was a full code. A review of the Quarterly Minimum Data Set (MDS) assessment dated 02/01/23, showed thatthe facility staff coded the resident as having severe cognitive impairment. Resident #29's medical record lacked documented evidence that the facility's staff offered the resident an opportunity to formulatean advanced directive. During a face-to-face interview conducted on 03/03/23 Employee #14 (Unit Manager 3 South) stated she did not know where the paperwork (Offer of Advanced Directive) was but it should bein the chart. 6. Resident #10 was admitted to the facility on 09/15/22 with diagnoses including: Acute Respiratory Failure, Congestive Heart Failure, Type 2 Diabetes Mellitus, Acquired Absence of Left Leg Below Knee, Acquired Absence of RightLeg Below Knee, and Bipolar Disorder. A review of the medical record revealed a facesheet showing that Resident #10 had a court-ordered representative. A MOST (Medical Orders for Scope of Treatment) form that was signed by the court-appointed guardian on 08/26/22. The MOST form indicated that the Resident was to be given CPR	F 578		

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F 578	Continued From page 18 (cardiopulmonary resuscitation) and receive full treatment in an emergency. The following instructions were on the second page of the MOST form: "... The MOST is a set of medical orders. The MOST does not replace an advancedirective An advance directive is encouraged for all competent adults. An advance directive allows a person to document in detail his/her future health care instructions. " A baseline care plan dated 09/15/22 under "Section E. Advance Directive/Code Status?" showed the words "Advance Directive" and contained no other information. A Physician's Order dated 09/15/22 read: "CPR(Full Code)." A Quarterly Minimum Data Set (MDS) assessment dated 01/24/23 documented a BriefInterview for Mental Status (BIMS) summary score of "12", indicating that the Resident had moderately impaired cognition. 4. Review of Resident #10's medical record lacked documented evidence that the facility's staff offered the Resident an opportunity to formulate an advance directive. The Resident had a MOSTform's care plan simply stated the words "Advance Directive," but provided no additional information. 7. Resident #53 was admitted to the facility on 12/11/20 with diagnoses including: Major Depressive Disorder, Paranoid Schizophrenia, Bipolar Disorder, Dementia, Epilepsy, PeripheralVascular Disease, and Generalized Muscle Weakness.	F 578		

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F 578	Continued From page 19 A review of the medical record revealed the following: -A "Letter of Guardianship," dated 10/09/20, and aface sheet showed that Resident #53 had a court-appointed guardian who was the Resident's representative. Annual Minimum Data Set (MDS) assessment dated 12/15/22 documented a Brief Interview for Mental Status (BIMS) summary score of "05", indicating that the Resident had severely impairedcognition. In addition, the Resident was noted as displaying fluctuating inattention. A Care Plan revised on 12/11/20 documented: "[Resident #53] has Advance Directive ... [Resident #53] has decided to remain Full Code..." A MOLST (Maryland Medical Orders for Life-Sustaining Treatment) form that included the guardian's informed consent and was signed by a physician on 12/11/20 (the Resident's date of admission into the facility). The MOLST form indicated that the Resident was to be given CPR (cardiopulmonary resuscitation) in an emergency. A Physician's Order dated 01/26/21 read: "CPR(Full Code)." Review of Resident #53's medical record lacked documented evidence of a current advance directive or that facility staff provided the Residentor the Representative information to formulate or refuse to formulate an advance directive. Resident#53's care plan documented that the Resident had an Advance Directive as of	F 578		

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F 578	Continued From page 20 12/11/20. The MOLST form in the Resident's medical record clearly stated, "..is valid in all health care facilities and programs throughout Maryland ...." The form did not indicate validity in any other state, and the form was dated threeyears ago, on 12/11/20. During a face-to-face interview on 03/02/23 at 12:18 PM, Employee #51 (Social Worker) statedthat advance directives were offered to residentsupon admission, quarterly throughout the year, and when there was a significant change in the Resident's health. During a face-to-face interview on 03/02/23 at 5:00 PM, Employee #29 (Director of Social Services) stated that if a resident has no AdvanceDirective, then upon admission, we offer a MOST(DC Medical Orders for Scope of Treatment) formand an Advance Directive to the Resident or theirrepresentative. For Resident #53, the Employee stated that sheknew the Resident had a MOLST form. The Employee added, "I emailed the MOST form to the Resident's representative, and the representative said [pronoun] would get it to me.For right now, the Resident is considered a Full Code." 8. Resident #247 was admitted from a local hospital to the facility on 08/18/21 with diagnosesincluding: Quadriplegia, Respiratory Failure, AtrialFibrillation, Epileptic Seizures, Anxiety, and Depression. A Review of Resident #247's medical record revealed:	F 578		

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F 578	Continued From page 21 A blank copy of a MOST (DC Medical Orders for Scope of Treatment) form that was not filled in or signed. A face sheet showed that Resident #247 wastheir own representative. A Care Plan revised on 10/17/21 documented: "[Resident #247] wishes to be a Full Code ...Interventions: Offer [Resident #247] information on advance directives, allow the Resident to formulate an advance directive if desired ......" A Physician's Order dated 11/01/21 read: "CPR(Full Code)." Review of Resident #247's medical record revealed a Quarterly Minimum Data Set (MDS)assessment dated 01/03/23 documented a BriefInterview for Mental Status (BIMS) summary score of "11," indicating that the Resident had moderately impaired cognition. During a face-to-face interview on 03/03/23 at 11:27 AM, Employee #29 stated the MOST and the Advance Directive forms are left with the Resident. We don't go into detail with them; we just provide it to them because that's a medical order ...we explain we're not Attorneys ....no one in this building can sign as a witness, and we provide suggestions for a notary .... The advance directive is also included in the Resident'sbaseline or comprehensive care plans." Review of Resident #247's medical record on 02/24/23 at 4:10 PM lacked documented evidence that facility staff provided the Resident	F 578		

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F 578	Continued From page 22 information to formulate or refuse to formulate an advanced directive. The Resident's comprehensive care plan included the Resident'scode status but provided no evidence that staff "allowed the Resident to "formulate an advanceddirective if desired," as stated in the interventionson the care plan. In addition, the Resident's MOST (DC Medical Orders for Scope of Treatment) form was not completed or signed.	F 580	1. R313 currently resides in the facility and has not suffered any ill effects. Resident'sRP was notified on 3/7/23 of resident's significant unplanned weight loss of 5.2% 2. The registered Dietician or designee will review current residents in the facility who had significant weight loss in the last 30 days to ensure that residents/ RPs are notified of the weight loss. All Residents with a weight variance have the potential to be affected. Findings showed that there were 5 residents that had a significant weight loss. All representatives were notified of the significant weight loss. All residents who represented themselves were also notified. 3.The DON/designee will in service Dietitian on 4/7/23 to ensure that residents/ RP's are notified of significant unplanned weight loss and it is documented in the medical record. 4.The Registered Dietitian or designee will review current residents with significant unplanned weight loss to ensure that residents/ representatives were notified. Audits will be conducted weekly x4 and monthly x3 until compliance is met. Any findings and results will be corrected immediately and reviewed by the in the QA and performance committee. Date of compliance 06/09/23.	06/09/2023
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiringphysician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure thatall pertinent information specified in §483.15(c)(2)is available and provided upon request to the physician. (iii) The facility must also promptly notify the			

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F 580	Continued From page 23 resident and the resident representative, if any,when there is- (A) A change in room or roommate assignmentas specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph(e)(10) of this section. (iv) The facility must record and periodicallyupdate the address (mailing and email) andphone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facilitythat is a composite distinct part (as defined in §483.5) must disclose in its admission agreementits physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidencedby: Based on record reviews, family interviews, andstaff interview for one (1) of 104 sampled residents, the facility's staff failed to notify a resident's family of the resident's significant unplanned weight loss of 5.2 percent from 11/12/22 to 12/21/22 [40 Days]. The findings included: Resident #313 was admitted on 11/11/22 with multiple diagnoses including Dysphasia, Lewy Body Dementia, Parkinson's Disease, and Stage4 Sacral Pressure Ulcer. A review of a nutritional assessment dated 11/13/22 documented, "Resident new admit ... wt.	F 580		

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(weight) 105 LBS (pounds) at lower end of norm[normal] for bmi (body mass index), residenthas puree diet. Rec (recommend) SLP (speech therapy) for best consistency ...currently beinf [being] fed by staff] ..."

Review of an Admission Minimum Data (MDS) assessment dated 11/18/22 documented, under the Cognitive Skills for Daily Decision-Making section, the resident was coded as "3" indicating the resident was severely impaired (never/rarely made decisions). Additionally, the resident was coded for requiring the physical assistance of onestaff member for eating.

A review of a document titled, "Weights and Vitals Summary", documented the resident's weights from 12/21/22 to 03/02/23 as follows: 11/12/22 - 105 pounds and 12/21/22 - 99.5 pounds.

Review of a dietician progress note dated 12/30/22 at 12:40 PM, documented, "...compareto weight on 11/12 (105# [pounds]) lost 5.5 Lbs(pounds) (-5.2%). BMI 17.6 indicates underweight. Resident continue on mechanical soft texture diet, tolerating meal with fair to poorpo (by mouth) intake 25 - 75%..."

A review of a complaint received by the State Agency (DC-11687) dated 02/22/23 at 4:28 PM documented, " ...My sister is nonverbal with earl (sp) signs of onsite dementia; and unable to make decisions for herself. When it's time to eat she says she not hungry mainly because she is unfamiliar with the staff ... The food is awful, and they [staff] don't care if the food is cold ...They [staff] rush through her feeding window ... Poor communication by staff ...[resident] weights about80 pounds ..."

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F 580	Continued From page 25 A review of Resident #313 medical record, including progress notes and nutrition assessments from 12/21/22 to 03/06/23 lackeddocumented evidence that facility's staff made the resident's family aware of the resident 5.2%significant weight loss. During a face-to-face interview on 03/06/23 at 10:14 AM, Employee #11 (Dietician) stated thatthe resident's family should have been informedof her significant weight loss of 5.2%. During a telephone interview on 03/06/23 at 11:51AM, the complainant (resident's sister) stated thatthe resident was not eating because she didn't like the pureed diet, the food was cold, and staff did not take the time needed to feed the resident.In addition, the complainant said that the family was not made aware of the resident's weight loss. Cross Reference F692, and 22B DCMR sect. 3211.1(a)	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, includingbut not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident touse his or her personal belongings to the extentpossible. (i) This includes ensuring that the resident can	F 584		

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F 584	Continued From page 26 receive care and services safely and that the physical layout of the facility maximizes residentindependence and does not pose a safety risk. (ii) The facility shall exercise reasonable care forthe protection of the resident's property from lossor theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,and comfortable interior; §483.10(i)(3) Clean bed and bath linens that arein good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lightinglevels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidencedby: Based on observations and interviews, it was determined that facility staff failed to provide the housekeeping services necessary to maintain a safe, clean, and comfortable environment, as evidenced by 1. torn privacy curtains in eight (8)of 52 resident's rooms, 2. soiled exhaust vents in15 of 52 resident's rooms, 3. trash thrown throughout the facility parking lot between February 21 and March 10, 2023, 4. two (2) of two (2) overly packed trash cans in the facility	F 584	1.The privacy curtains in room 106, 147, 158, 159, 160, 257, 307 and 330 were replaced on 2/24/23. Soiled exhaust vents in room 143, 152, 159, 217, 227, 228, 250, 308, 315, 329, 333, 337, 348, 351, and 351 were cleaned on same day of observation by maintenance team. The scattered trash noted throughout the parking lot was removed on same day of observation by Environmental service team. The two (2) trash receptacles were emptied. The expired items in the dental office were discarded. 2. The Environmental Service Director or designee will review the current residents' rooms to ensure that all privacy curtains in the residents' room are not torn, that the parking lot is free from scattered trash and the trash receptacles in the parking lot are not overly full of trash. The Maintenance Director or designee will review the current resident's bathroom exhaust vents to ensure they are not soiled. The Director of nursing or designee will check the dental office to ensure that there are no expired supplies present. All residents have to potential to have a torn curtain in their room and dirty exhaust vents in the bathroom. All trash cans have the potential to be overfilled. The dental office has the potential to have expired supplies. Findings showed that several curtains required replacement while others just required additional hooks or to be washed. All issues were corrected. 3.The Environmental Director or designee will in service the environmental service staff to ensure that all privacy curtains in the residents' rooms are not torn, that the parking lot is free from scattered trash and the trash receptacles in	6/9/2023

the parking lot are not overly full of trash.

The maintenance Director or designee will in service the maintenance staff to ensure that exhaust vents in the bathrooms are not soiled.

The Director of nursing or designee will in service the central supply staff and the Dental staff to ensure that expired supplies are not kept in the Dental office.

4.The Environmental Director or designee will conduct random room rounds of resident rooms to ensure that privacy curtains are not torn until compliance is sustained. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.

The Environmental Director or designee will monitor the parking lot at least twice per day to ensure that the parking lot is free from trash and ensure the parking receptacle are not overflowing.
Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

The Maintenance director or designee will conduct random room rounds to ensure that the residents exhaust vents in the bathroom are not soiled. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

The Director of nursing or designee will monitor that the dental office does not have any expired supplies. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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F 584	Continued From page 27 parking lot, and 5. expired dental items in the dental office. The findings included: During an environmental walk-through of the facility on February 23, 2023, between 1:30 PM, and 4:00 PM, and on February 24, 2023, between 10:35 AM and 12:00 PM the following were observed: 1. Privacy curtains in resident rooms #106, #147, #158, #159, #160, #257, #307, and #330 were observed torn. 2. Exhaust vents were noted to be soiled in the bathroom of resident rooms #143, #152, #159, #217, #227, #228, #250, #308, #315, #329, #333, #337, #348, #351, and #352. 3. Throughout the facility parking lot on February 21, 2023, to March 10, 2023, observations were made of trash scattered throughout the facility parking lot. The items included: used gloves, used face masks, used face shields, empty plastic containers, and various debris. 4. Two (2) of two (2) trash receptacles located in the facility parking lot were excessively filled with trash on various occasions during observations from February 21, 2023 to March 10, 2023. 5. Several items used in the dental office were expired. These items included: -Two (2) of two (2) unopened boxes (60 tablets per box) of Polident Denture cleanser expired as of 7/21/2021. -Two (2) of (2) open boxes of Polident Denture cleanser expired as of 4/28/2021 and 5/3/2021.	F 584		

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F 584	Continued From page 28 -One-third full one-gallon container of Cavicide Surface disinfectant cleaner expired as of 10/1/2022. -One (1) of one (1) 305 ml container of Impression Material Putty expired as of 1/28/2021. -One (1) of one (1) 305 ml container of Impression Material Putty with expiration labeltorn. -One (1) of one (1) 800 grams container of Vac Attak High Proficiency Evacuation System cleaner expired as of 7/2018. These findings were acknowledged by Employee #3 on March 10, 2023, at approximately 8:00 PM	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entitythat hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTCfacility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make informationon how to file a grievance or complaint availableto the resident.	F 585		

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F 585	Continued From page 29 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolutionof all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policyto the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact informationof the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phonenumber; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State SurveyAgency and State Long-Term Care Ombudsmanprogram or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigationsby the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident	F 585	1. A locked box for anonymously filing grievances will be available on each floor for residents/representatives. A written follow up was provided to the complainant for grievances filed on February 2023. R272 currently resides in the facility and has been notified of locked boxes availableto file grievances anonymously. Resident council will be informed on 06/01/2023 about locked boxes being available on each floor to anonymously file grievances and informed that facility will provide written follow up to their grievances. 2. Grievances filed in the last 30 days will be reviewed by social services to assure that resident/representative complaints were provided written follow up. All residents have the potential to be affected. Findings showed that there were no options for residents to anonymously file their grievances. 3. The social worker director or designee will in-service the facility staff on the locations of the locked boxes. The boxes were mounted on 5/16/23 on all floors including by the Social Work Director's office door on the first floor and by the social worker's office on the second floor, so that residents/complainant can anonymously file a grievance(s) and follow up will be provided. 4. The Social Worker Director or designee will review grievances to assure that a written follow up is provided to the complainant. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance	06/09/2023

committee. Date of compliance 06/09/23

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F 585	Continued From page 30 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; andas required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusionsregarding the resident's concerns(s), a statementas to whether the grievance was confirmed or notconfirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violationof the residents' rights is confirmed by the facilityor if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidencedby: Based on observations, record review, resident interview and staff interview, the facility's staff failed to ensure residents were able to file grievances anonymously and receive written decisions regarding their grievances.	F 585		

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F 585	Continued From page 31 The findings included: Review of a policy tilted, "Resident and Family Grievances" dated 02/02/22 documented, " ... A grievance may be filed anonymously ...In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decisionon the grievance to the resident or representativeat the conclusion of the investigation. Multiple observations of the facility including six units, common areas, and dining areas from 02/10/23 to 03/02/23, revealed there were no physical mechanisms (for example, a drop box)for residents to anonymously file a grievance. A review of the facility's Grievance Book revealeda document titled "Compliant Tracking Log" for February 2023. There were ten (10) grievances listed in the grievance log. According to the log, eight (8) of the 10 grievances had been resolved.However, review of the eight individual grievances revealed there was no documented evidence that the complainant was provided witha written decision related to their grievances. During a face-to-face interview on 02/16/23 starting at 6:32 PM, Resident #272 stated he hadfiled many grievances, but he had not received awritten decision. The resident was asked if he could file his grievance anonymously. He stated he had to provide his complaint in writing to the nursing staff and "hoped they would submit it." During the Residents Council Meeting on 02/28/23 at 2:30 PM, residents reported having tosubmit their complaints to the nursing staff, who then sent them to the Grievance Officer.	F 585		

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Additionally, residents said that when they submit grievances, they do not receive any response in writing from the facility.

During a face-to-face interview on 03/02/23 at 12:30 PM, Employee #60 (Grievance Officer) stated that nursing staff submitted resident grievances to her mailbox. When asked if residents could anonymously submit their grievances, the employee said that residents could place grievances under the locked doors ofthe administration office. Employee #60 was asked if she was the only one who could see the grievance in that area, and Employee #60 stated,"No." Additionally, she stated that she respondedto residents' grievances verbally and was not aware of documentation requirements.

Cross reference 22B DCMR sect. 3233.4

F 600 SS=G — Free from Abuse and Neglect
CFR(s): 483.12(a)(1) — F 600

§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 totreat 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

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F 600	Continued From page 33 by: Based on observations, record reviews, and staff interviews for six (6) of 105 sampled residents,the facility staff failed to ensure residents werefree from abuse. (Residents #146, #163, #254, #70, #131 and #169.) Actual harm was determined to be present for Residents #169, and #131. The findings included: A review of a policy titled "Abuse, Neglect and Exploitation" revised on 09/20/22, documented " ...The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessmentif needed: Increased supervision of the alleged victim and residents ...Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse ...Protection of Resident The facility will make efforts to ensure all residents are protectedfrom physical and psychosocial harm as well as additional abuse, during and after the investigation ...Taking all necessary actions as a result if (sp) the investigation, which may include but are not limited to, the following: Analyzing theoccurrence (s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; Defining	F 600	1.R146, R163, R254, R70, R131, and R169 currently reside in the facility offered emotional support and noill effects noted at this time. R169 was placed on 1:1 monitoring on 5/8/23 R131 was placed on 1:1 monitoring on 5/8/23 R70 was separated from R169 on 10/24/2022 and assessed by psych services on 10/24/2022 by staff and assessed to assure that resident was provided coping strategies to utilize when frustrated. R254 is on 1:1 monitoring, since 8/16/22 and interventions will be reviewed. R146 was placed on 1:1 monitoring on 2/21/23; psych services were consulted to assure that resident was provided counseling to deal with sexualdesires/behaviors. R163 seen by psych services on 6/6/23. E20 and E21 provided education on supervision of residents on 1:1 monitoring to promote safety. 2. There were 6 reported (FRI) incidents in the last 30 days which were reviewed by The Director of nursing or designee to ensure that interventions were inplace to provide supervision and residents were free from abuse. Findings showed that proper supervision was implemented as evidenced by no additional incidents with the identified residents. 3.The Clinical consultant or designee will provide education to all facility staff on policies and procedures for abuse prohibition.	06/09/2023

			4. The Director of nursing or designee will review facility reported incidents (FRI) related to resident-to-resident altercation to ensure that interventions were in place to provide supervision and residents are free from abuse Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	

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(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 600	Continued From page 34 how care provision will be changed and or improved to protect residents receiving services; ...Identification of staff responsible for implementation of corrective actions; .... " 1. Facility staff failed to prevent Resident #169 from repeated episodes of abuse due to inadequate supervision which resulted in physicalaltercations. Resident #169 was admitted to the facility on 01/03/19 with multiple diagnoses that included Tobacco Use, Unspecified Dementia, and Altered Mental Status. Review of Resident #169's medical record revealed a care plan initiated on 05/25/22 with afocus area of " .... [Resident #169] has exhibit (ed) (sp) aggressive behavior while in the smoking patio due to dx (diagnosis) of dementia with behavior disturbance....... " had the following interventions "Monitor for aggressive behavior ...psych (psychiatry) consult for medication review ..." [SBAR (situation background assessment recommendation) -Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool] dated 06/21/22 at 9:06 PM " ...It was reported to this writer that resident grabbed CNA (certified nurse aide) staff's shoulder at about 6:25 PM........ resident was separated and was redirected. On assessment resident was unable to remember what exactly transpired in the dining room on first floor " There was no documented evidence in the medical record that the facility provided interventions in the care plan to address theresidents' symptoms of	F 600		

Dementia.

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F 600	Continued From page 35	F 600		

A review of the Quarterly Minimum Data Set (MDS) assessment dated 09/11/22 showed that the facility staff coded the following: severe cognitive impairment, physical behavioral symptoms directed towards others (e.g., kicking pushing, scratching, grabbing, abusing others sexually) that occurred in 1 to 3 days. The Resident was also coded as having verbal behavioral symptoms directed toward others (e.g.threatening others, screaming at others, cursing at others) occurred in 1 to 3 days. The identified symptoms put the resident at significant risk for physical illness or injury, interfered with the resident's care, put others at significant risk for physical injury, and significantly disrupted care orliving environment. The facility staff coded the resident as having no impairment in the upper or lower extremity.

Further review of Resident #169's medical record revealed a situation background assessment recommendation (SBAR) -Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool] dated 09/17/22 at 4:54 PM documenting, " ...It was reported to this nurse that resident hit his roommate [...] on the head with his walking cane at about 11:45 am. Resident denied hitting his roommate with his cane.
Resident refused assessment ..."

An SBAR -Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool] dated 10/02/22 at 9:37 AM documented, " ...[Resident #169] initiated a physical altercation with one of the resident ... while in the smoking patio, when he tried to snatch cigarette ..."

A [Nurses Note] dated 10/24/22 at 12:38 PM

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F 600	Continued From page 36 documented, " ...Seen [Resident #169] sitting in the chair in the first floor closed (sp) to elevator when (...) started hitting him in his face and (Resident #169) got up and swung back at him and she redirected [Resident #169] to get on elevator ...Assessment was done. No redness orbruise noted on [Resident #169] was noted with abump on his right left forehead, he complaint (sp)of pain during assessment in scale 4/10." Review of a care plan date initiated 10/24/22, witha focus area of "[Resident #169] had resident to resident interaction with (Resident name) 10/24/22" had the following interventions "Administer Tylenol (analgesic) 325 mg (milligrams) 2 tabs po (by mouth) prn (as needed)for pain ...Apply ice compress x (times) 10 minutes on his forehead every shift x 24 hours ...Police was called, no file case was made ...Psych (Psychiatry) consult to evaluate ..." A nursing progress note dated 01/19/23 at 5:02 PM documented, "Report received around 2:50 PM resident was involved in a physical interactionwith another male resident. Resident sustained minor injury to his right forehead, and right lower leg ..." A facility-reported incident (FRI) dated 1/19/23 indicated Resident #169 sustained a skintear to his right lower leg, and abrasion to his rightforehead. An additional progress note dated 01/19/23 at 6:51 PM documented, "...[Provider Name] was notified and order given as follows , Right forehead abrasion- Cleanse with NSS (Normal Saline Solution) pat dry apply bacitracin (Topicalantibiotic ointment) leave open to air. Right lowerleg skin tear- cleanse with NSS (Normal Saline Solution) pat dry ...[Resident #169] was	F 600		

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F 600	Continued From page 37 interviewed, he stated that the guy punch him onhis face and he did not know he hit him and stated that he hit back........................." A FRI submitted to the State Agency on 02/21/23, documented, " ..... On February 16, 2023 at approximately 1:00 PM, an alleged resident to resident physical altercation was reported. It was communicated that residents (Resident #131 and Resident #169) had a heated exchange which resulted in a scuffle while they were out on the smoking patio. The residents were immediately separated." Nursing progress note dated 02/16/23 at 12:26 PM noted, "Around 10:49 AM this morning, writerheard loud voices and went towards the voices. On approaching the first floor Dining room, writer observed [Resident #169] on the floor near the vending machine towards the rear of the Dining Room, with [Resident #131] astride him. The residents were separated. There was no apparent injury upon assessment .... " Review of a care plan revised on 02/18/23, revealed the following focus area: "[Resident #169] has a behavior r/t (related to) wandering onthe hallways, attempting to enter other resident'srooms/staff offices, invading in roommates space/privacy. has behavior of picking cigarette butt in the smoking patio ....Behavior of begging for cigarette from other resident while in smoking patio." The following interventions were noted, "administer medications as ordered, anticipate and meet needs, hourly monitoring for safety, Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situationand take to alternate location as needed."	F 600		

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F 600	Continued From page 38 Review of a document provided by the facility titled "smoking monitors" dated 02/23/23, listed Resident #169's name and six other Residents' names stating, "When these residents are on thesmoking patio or waiting to enter the smoking patio, please monitor them to ensure they do notinteract negatively with other residents." During a face-to-face interview conducted on 02/28/23 at 12:55 PM, Employee #18 (Unit Manager 3 South) acknowledged the findings andstated, "(Resident #169) was actually asking everyone for a puff of their cigarette. They startedtussling (fighting) and ended up on the floor. I asked [Resident #169] what happened, and he had no memory of the altercation ...I spoke with the family about the issues." 2. Facility staff failed to prevent an episode of abuse in which Resident #70 and Resident #169were engaged in a physical altercation. Resident #70 was admitted to the facility on 08/05/2013 with multiple diagnoses that includedthe following: Disorder of the Brain, Bipolar Disorder, Restlessness and Agitation, Schizoaffective Disorder, and Difficulty Walking. A review the Quarterly Minimum Data set (MDS) dated 09/16/22 revealed that the facility staff coded the resident as having moderately impaired cognition. Facility staff coded that the resident did not present any symptoms of psychosis or behavioral symptoms and the resident had no impairment of the upper or lowerextremity. A Nursing Progress Note dated 10/24/22 at 3:45	F 600		

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F 600	Continued From page 39 PM documented, " ...[Resident #70] hit another resident while in the hallway. Resident noted with open area to right hand knuckle. When asked what happened resident said he got into an altercation with another resident and punched him. Resident was taken to his unit for assessment. Hand assessed and resident denied pain at site ..." A review of a Facility Reported Incident (FRI) submitted to the State Agency on 10/24/22 documented " ...Report received that this morning around 8.40 AM, resident hit another male resident [Resident #169]. [Resident #169] refusedassessment. It in (is) unknow (sp) where [Resident #169] was hit as [Resident #70] did notdisclose. Observed [Resident #70] with open area to his right knuckle area. [Resident #70] admitted to hitting [Resident #169] because [Resident #169] sat in a chair belonging to another resident ..." A Psychiatric Progress Note with Therapy Services 10/24/22 at 8:00 PM noted, " ...seen s/p(status post) Physical interaction with peer, He was seen in his room sitting in his chair, calm, cooperative, easily engaged, during inquiry of thattranspired with the incident with his peer, he stated that "I was protecting the other resident, one resident was sitting on the chair then went out to use the bathroom, then the resident from 3rd floor came over and sat on the chair, I was telling the guy to got (get) up and he push me 3X (times), and I hit him on his face ..." The medical record lacked any documented evidence that the facility provided adequate supervision to prevent an altercation between Resident #70 and Resident #169.	F 600		

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During a face-to-face interview conducted on 02/28/23 at approximately 1:15 PM, Employee #3 (Director of Nursing) stated that when there is a resident-to-resident physical altercation, staff separate them.

3. Facility staff failed to prevent Resident #131 from repeated episodes of abuse due to inadequate supervision which resulted in physicalaltercations with Resident #254 and Resident #169.

Resident #131 was admitted to the facility on 02/03/17 with multiple diagnoses that included thefollowing: Dementia, Bipolar Disorder, and Alcohol Abuse.

A review of a Facility Reported Incident (FRI) DC00010890 submitted to the State Agency on 07/25/22 documented the following: " ...At about 4:05 pm report received that [Resident #131] ... and [Resident #254] were involved in a physical altercation and [Resident #131] sustain a laceration on the left upper cheek. [Resident #131] was transported to the (Hospital name) ..."

A review of a Facility Reported Incident (FRI) submitted to the state agency on 01/19/23 documented the following: "Report received that resident [Resident #131] was involved in a physical altercation with resident [Resident #169]today at 2:50 pm, as he entered the first-floor dining room. Allegedly [Resident #131] was hit by[Resident #169] in the face and a fight ensued ..."

A review of a Facility Reported Incident (FRI) submitted to the state agency on 02/16/23 documented the following: "Around 10.49 am this

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F 600	Continued From page 41	F 600		

morning, writer heard loud voices and went toward the voices. On approaching the first-floor dining room writer observed [Resident #131] astride [Resident #169] ...on the floor near the vending machine towards the rear of dining room.The residents were separated. There was no apparent injury ..."

A review of the medical record revealed the following:

[Physician Order] 10/20/21 "Monitor for: Specify behaviors yelling, screaming, resisting care, applying soap to his body, anxious document inprogress notes every shift ..."

A review of Resident #131's Quarterly Minimum Data Set (MDS) dated 07/24/22, revealed that thefacility staff coded the resident as having a moderate cognitive impairment and no impairment in the upper or lower extremity. The facility staff coded the resident as having no symptoms of psychosis and no behavioral symptoms.

[Physician Order] 07/02/22 "Monitor for any behaviors. Resident is prescribed a psychotropic medication ..."

[Nurse Practitioner Progress Note] 7/25/2022 at8:46 PM "The nursing staff reported that the patient had a physical Altercation with another in-house patient [Resident #254] and sustainedaninjury to his left cheek. Plan: The patient was transferred to ER for continuity of care."

[Nurses Note] 7/26/2022 at 2:59 PM " S/P (statuspost) ER transfer: Resident returned to unit @1:30pm from hospital transfer. Resident has

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F 600	Continued From page 42 hematoma of the left eye as well as a laceration above left eye that he received stitches. Residentdenies any pain at this time. Residents vitals were154/90, (p) 74,(r) 22, and (t) 97.6 ax.. Resident was encouraged to take a shower, but declined. Was able to get resident to change from bloody clothing and perform am care to himself at the bedside. Resident has new orders for Keflex 500mg 2 times a day. Resident did not verbalize any concerns for nurse." [Treatment Administration Record (TAR)] 07/27/22, " ...Left below eye laceration repaired site: Apply Bacitracin (topical antibacterial) to siteevery day shift." [Psychological Services Supportive Care progress note] 07/28/22 at 8:21 AM " ...Met with patient today at the request of the facility after hewas assaulted by another resident ...Asked patient what happened between he and the otherresident. Patient stated " I don't remember anything" Patient doesn't remembe3r (sp) being taken to the ED for treatment or anything else that happened ..." [Nursing Progress Note] 01/19/23 at 5:31 PM "Report received that at 2.50 pm, resident was involved in a physical interaction with another male resident. [Resident #131] did not sustainany injuries ..." [Nursing Progress Note] 01/19/23 at 7:39 PM " ... [Resident #131] was seen to follow up regardingthe incident that was reported while in the smoking patio. Mr. [Resident #131] don't have any recollection of any involvement in the smoking patio. Assessment was made, no any bruise or redness on his hand, no sign of any	F 600		

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F 600	Continued From page 43 injury noted, he stated that he is fine ..." [Care Plan] initiated on 1/19/23, Focus :"[Resident #131] has a physical aggression withother resident [Resident #169] while in a smokingpatio" Interventions: "Police was called no arrest was made. Psych (psychiatry) consult to evaluate emphasize to [Resident #131] to refrain from any physical aggression towards other resident while in the smoking patio." [Physicians Order] 02/01/23 "Hourly check to know residents where (sp) about due to noncompliance with wearing wander guard or keeping it in place post placement every shift." [Treatment Administration Record] 02/01/23- 02/18/23, "Hourly check to know residents whereabout due to non-compliance with wearing wander guard or keeping it in place post placement" Review of the (Treatment Administration Record) TAR from 02/01/23 through 02/18/23 shows that the facility staff checked off one time for one of three shifts (Day, Evening, Night). There was no documented evidence in the medical showing that staff monitored Resident #131's hourly whereabouts on or off the unit. [Nursing Progress Note] 02/16/23 at 12:32 PM "Around 10.49 am this morning, writer heard loud voices and went towards the voices. On approaching the first floor dining room, writer observed Mr. [Resident #131] on the floor near the vending machine towards the rear of the dining room, astride Mr. [Resident #169]. The residents were separated. There was no apparent injury "	F 600		

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F 600	Continued From page 44 [Care Plan] initiated on 02/16/23, Focus: "[Resident #131] had a resident to resident interaction with [Resident #169] while in the first dining room" Interventions: "Emphasize to [Resident #131] to stay away from [Resident #169], Encourage [Resident #131] to report issueand concern to staff .... Encourage to refrain from being aggressive towards other residents and report any disagreement he has with other residents to staff ......" [Incident Note] 02/18/23 at 12:37 AM "........IDT (interdisciplinary team) had a meeting regardingMr. [Resident #131] interaction with [Resident #169] 2/16/23 .... it was concluded that the root cause is due to poor impulse control and h/o (history of) of aggression. Following intervention in place: Encourage to refrain from being aggressive towards other resident and report anydisagreement he has with other resident to staff. Psych (Psychiatry) consult for evaluation. Encourage {Resident #131] to stay away from [Resident #169]. Police was called no arrest was made. Nursing staff will continue to monitor........." The facility staff provided the Surveyor with a document dated 2/23/23 titled "Smoking Monitors" which was reviewed and it stated "When these residents are on the smoking patioor waiting to enter the smoking patio, please monitor them to ensure they do not interact negatively with other residents: [Resident #169][Resident #131] (other residents names were listed and the total number was seven (7) residents named on the list. Resident #131's medical record lacked documented evidence that the facility staff	F 600		

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F 600	Continued From page 45 provided adequate supervision to prevent Resident #131's multiple resident to resident altercations. During a face-to-face interview conducted on 02/28/23 at 12:55 PM, Employee #18 (Unit Manager 3 South) stated that Resident #131 started fighting with Resident #169 after he askedhim for a puff of his cigarette in the designated smoking area. After the incident when questioning Resident #131 about the physical altercation that occurred Resident #131 had no memory of it. During a face-to-face interview conducted on 02/28/23 at 2:11 PM, Employee #40 (Smoke Monitor) stated that the altercation started outsideafter [Resident #169] asked [Resident #131] for apuff of his cigarette then more words were exchanged, and the residents started to fight. 4. Facility staff failed to prevent the non-consensual contact of one resident (Resident#146) towards another resident (Resident #163). A. Review of Resident #163's medical record revealed the Resident was admitted to the facilityon 05/18/20 with diagnoses including: Cerebrovascular Accident, Hemiplegia, Type 2 Diabetes Mellitus, Depression, and Anxiety. A Care Plan dated 06/06/22 revealed: "Focus: [Resident #163] has been accused of alleged sexual abuse (accuser). Goal: [Resident #163]will not be involved in alleged sexual abuse through the next review date x 90 days. Interventions: Hourly monitoring till seen by psych ...[Resident #163] moved from 307A to 201B	F 600		

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F 600	Continued From page 46 ...Psych consult due to alleged abuse." Resident #163's medical record revealed a Quarterly Minimum Data Set (MDS) assessmentdated 02/18/23 documenting a Brief Interview forMental Status (BIMS) summary score of "15", indicating that the Resident had intact cognition. In addition, the MDS assessment noted that the Resident had lower extremity impairment on oneside, used a wheelchair for mobility, and requiredsupervision (oversight, encouragement, and cueing), by facility staff for locomotion on and offthe unit. B. A review of Resident #146's medical record revealed that the Resident was admitted to the facility on 08/30/18 with diagnoses including: Schizoaffective Disorder, Alcohol Abuse, Anxiety Disorder Unspecified, and Dementia. A Care Plan dated 09/17/18 documented: "Focus:.. Resident have (has) a behavior of scratching /touching [pronoun] private area in public r/t (related to) impaired cognition Goal: Resident #146 will be redirected and reoriented ...Interventions: Anticipate and meet [Resident #163] 's needs. If reasonable, discuss behavior. Explain /reinforce why (the) behavior is inappropriate ...Provide a program of activities that is of interest ...Psych consult initiated for indecent exposure ...." A Psychiatric Progress Note dated 09/08/22 at 12:30 PM documented: "....... staff reported that [Resident] (had) been exposing [self] inappropriately to ...peers....... Counseling was given, discussed consequences if [pronoun] continues to act inappropriately .... Treatment Plan	F 600		

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(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 600	Continued From page 47 Recommendations: ...Continue with behavioral monitoring." Review of the Resident's medical record revealeda Quarterly Minimum Data Set (MDS) assessment dated 09/27/22, which documented aBrief Interview for Mental Status (BIMS) summaryscore of "03", indicating that the Resident had severely impaired cognition. In addition, the MDS assessment noted that the Resident showed wandering behavior, physical behaviors (e.g., scratching, grabbing, abusing others sexually), and verbal behaviors towards others (e.g., threatening others, cursing at others). The MDS also showed that the Residentcould ambulate without staff assistance or the use of an assistive device, and was not on antipsychotic medications. A Physician's Order dated 01/19/23 at 9:05 PM directed: "Hourly monitoring due to resident's exhibiting indecent sexual behavior every shift." Discontinued 02/21/23 at 11:38 PM. A Psychiatric Progress Note dated 01/23/23 at 12:00 PM documented: " ...requested to assess(the) patient for 1:1 placement and for possible discontinuation ...Stated, 'I did not do anything toanybody' ... Treatment Plan Recommendations: ...D/V (direct vision) 1:1 line of sight. Start closed observation for behavior, Supportive therapy provided, Continue with behavioral monitoring, F/U (follow-up) as needed.." Review of a Facility Reported Incident (FRI) (DC00011688) dated 02/21/23 at 9:29 PM documented, "At about 9 PM on 02/21/23 [Resident #163] came and reported to this writer	F 600		

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	095022	A. BUILDING ______ B. WING ______	C 03/10/2023

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F 600	Continued From page 48 that [Resident #146] touch(ed) [pronoun] on [pronoun] chest while on the first-floor dining (sp.) (dining) room and [pronoun] does not like that. There was no injury reported or noted on [Resident #163]. (The) Investigation is in progress ..." A Physician's Order dated 02/21/23 at 9:38 PM directed: "1:1 monitoring due to resident's exhibiting indecent sexual behavior every shift." A Psychiatric Progress Note dated 02/22/23 at 10:00 AM documented: " ...asked to evaluation (evaluate) patient for exhibiting high libido by exposing [self]to female peers ...Denied allegation and stated, 'I don't know what you aretalking about ...Collateral information received from staff, staff report patient exposing [self] to women peers ...Chart and medication reviewed ..." A Care Plan revised on 02/24/23 documented: "Focus: ......02/20/23 [Resident #163] exposed [pronoun] private part in public - Inappropriate sexual behavior/inappropriate sexual touching; Goal: Resident #163 will not expose [pronoun] private part in public area; Interventions: .. Redirect resident whenever [pronoun] is scratching /touching [pronoun] private area in public " Review of a summary update to the FRI (DC00011688) submitted on 02/26/23 at 8:04 PM documented, " ..... [Resident #163] reported that [Resident #146] touched [pronoun] chest without [pronoun] consent while they were in the first-floor dining room ...full assessment was completed ... [Resident #163] had no evidence of injury ...denied pain or any additional concern ...	F 600		

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F 600	Continued From page 49 [Resident #146] was interviewed by the clinical manager. When [pronoun] was asked about what occurred [pronoun] stated, 'I don't know. What are you talking about?' ...According to witness statements, [Resident #146] touched [Resident #163] 's shoulder and said, "Excuse me," then asked [pronoun] for a cigarette.[Resident #163] was not seen touching [Resident 163] 's chest. Based on a full investigation and review of witness statements, the facility was not able to substantiate the alleged sexual assault ...providerfor both residents was made aware ... Metropolitan Police were informed ...no arrests and no charges filed ... [Resident #163 was encouraged to stay away from [Resident #146]." A 02/27/23 at 10:AM [Psychiatric Progress Note] documented: " ...asked to evaluation (evaluate) patient for exhibiting high libido and by touching [pronoun] female peer inappropriately... Denied allegation and stated, 'You all are lying on me.' ...was counseled but patient not receptive to counseling. Collateral information received from staff, report patient exposing [self] to......... peers." Review of a Nurses Note on 02/27/23 at 5:30 PM documented: "Investigation was reviewed again due to the need for clarification of statements. Based on clarification of statements the allegationwas substantiated. Resident will be seen by Psych for appropriate interventions.......................resident is currently on 1:1 monitoring. Team will assign male staff as much as possible. Continue POC(plan of care). Review of an addendum to the Facility Reported Incident (FRI) (DC00011688), submitted on 02/28/23 at 9:41 PM documented: '....................... After further investigation, the facility substantiates the	F 600		

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F 600	Continued From page 50 resident to resident alleged sexual assault reported by [Resident #163] at 9 PM on February21, 2023. An eyewitness saw [Resident #146] touch [Resident #163] 's chest just before [pronoun] touched [pronoun] shoulder and asked[pronoun] for a cigarette ...Staff will continue to redirect [Resident 146] ... will remainon constant monitoring until further notice." During a face-to-face interview on 02/23/23 at 04:54 PM, Resident #163, stated that "We were in the cafeteria. I was in my wheelchair, and Resident #146 was walking past me. The Certified Nurse's Aide (CNA), walking with Resident #146 was not paying attention; the CNAturned away from Resident #146 and was talkingto another resident. As we were passing each other, Resident #146 said, 'Hey don't I know you?Come here, and [pronoun] reached down and touched my chest. They (the facility) called the police and asked me questions, but they do nothing about this resident. This was not the first time [pronoun] touched me. Another time when we were passing each other in the hallway, the Resident said to me, 'Come to my room,, let's go ...' After that I was moved to the first floor. A time before that when I was on the third floor, another resident said that while I was asleep, [pronoun] saw the Resident masturbating outside the doorway in front of my room. The facility knew about the Resident's behavior because [pronoun]was asking everyone [other residents] to performan oral sex act." Resident #163 could not recall the specific dates that the other two incidences with Resident #146 occurred. During a face-to-face interview on 02/27/23 at approximately 11:30 AM when asked about the incident where [pronoun] touched Resident	F 600		

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F 600	Continued From page 51	F 600		

#146's chest, Resident #163 stated, 'I would liketo do that, but didn't know anything about that incident.'

During a face-to-face interview on 02/27/23 at approximately 11:30 AM, Employee #20 (CNA/1:1 Monitor assigned to Resident #163] from 02/25, 02/26, and 02/27/23, stated the for the past three days, the Resident kept asking the Employee to get [pronoun] a woman.

During a telephone interview on 03/10/23, Employee #21 (CNA/1:1 Monitor for Resident #146 on 02/21/23) stated that [pronoun] was walking shoulder to shoulder with Resident #146in the first-floor dining room. As Resident #146 was walking past other residents, he was askingfor a cigarette. When Resident #146 walked pastResident #163, [pronoun] asked [Resident #163]for a cigarette. Resident #163 said, 'No." and [Resident #146] touched [Resident # 163] on theshoulder. Resident #146 never touched Resident#163's breast.

When asked if the facility offered the CNA any formal training on 1:1 monitoring of residents, the CNA responded, "I never received specific training on 1:1 monitoring from the facility. I had been a 1:1 monitor for other residents in the facility but had never been assigned to Resident #146 before the day of the incident. I had seen theCNA assigned to Resident #163 the shift before me, walking around the facility with the Resident,so I did what I had seen that CNA do."

Review of this evidence showed that facility staffhad knowledge and documentation of Resident #146's sexual behaviors towards other residentsin the facility before the incident on 02/21/23 with

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F 600	Continued From page 52 Resident #164. Cross Reference 22B DCMR sect. 3269.1 (l)	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and proceduresto investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with theQAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of theAct. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidencedby: Based on record reviews and staff interviews for	F 607		

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F 607	Continued From page 53 one (1) of 105 sampled residents, facility staff failed to implement its policies and procedures for investigating allegations of abuse, neglect, and injuries of an unknown source. (Resident #237) The findings included: A review of the facility's policy titled "Abuse Neglect and Exploitation" with a revision date of 09/20/22, documented " ...An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include ...focusing the investigation on determining if abuse, neglect,exploitation and or mistreatment has occurred, the extent and cause and providing complete andthorough documentation of the investigation. ...Reporting/Response The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency and to all other required agencies ...withinspecified timeframes ..." 1. Facility staff failed to report Resident #237's fallthat the resident reported to staff that occurred when the resident was walking back to the facilityfrom the community. Resident #237 was admitted to the facility on 12/03/21 with multiple diagnoses that included thefollowing: Asthma, Heart Failure Unspecified, andOther Abnormalities of Gait and Mobility. A review of the Quarterly Minimum Data Set (MDS) dated 09/08/22, showed that the facility staff coded that the resident is cognitively intact,needing supervision and a one-person physicalassist for locomotion on and off the unit, and	F 607	1. R237 currently resides in thefacility and has no ill effects noted. 2. There were 15 fall incidents in the last 30 days which were reviewed on 5/19/23 by the Director of Nursing or designee to assure that investigations were completed to rule out abuse, neglect, and injuries of unknown source. Any identified issues were reviewed and resolved. 3. The Nurse educator or designee will in-service the licensed professional nurses to ensure that the facility's policies and procedures for investigating allegations of abuse, neglect, and injuries of an unknown source are followed. Abuse training will be upon hire and yearly. 4. The Director of nursing or designee will review incidents related to falls to ensure that the facility's policies and procedures for investigating allegations of abuse, neglect, and injuries of unknown source are followed. Audits will be completed weekly x4 and then monthly x3. All issues will be corrected immediately, and audits will be submitted and reviewed with the QA and performance committee. Date of compliance 6/7/23.	06/09/2023

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F 607	Continued From page 54	F 607		

having no impairment in the upper or lower extremity.

Review of Resident #237's medical record revealed:

-[Nursing Progress Note] 09/16/22 at 9:29 PM, "resident (sp) (Resident) returned from LOA (Leave of Absence) around 9 pm. upon arrival pt (patient) alert and oriented X (times) 4 (person, place, time, situation) but appeared to be tiered (sp) (tired). she complained left shoulder pain. Ptstated (sp) (stated) "I tripped on something on myway back to the facility and stained my left shoulder while I tried to prevent from falling" RN (registered nurse) assessed resident and no signof dislocation or fracture noted. Possible muscle strain due to putting her weight on her arm and her walker. Pt stated only her left knee touch the floor. No injury to bilateral knees. Pain medication administered and encourage to take rest ... SBP (systolic blood pressure) elevated 171. possibly because resident did not take her BP (blood pressure) medication on time ..."

-[Nursing Progress Note] 09/16/22 at 11:22 PM"BP (blood pressure) rechecked and it was 150/85. Resident her pain is almost the same 5/10. we will continue to monitor resident.

-[SBAR (Situation Background Assessment Recommendation) -Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Note] 09/19/22 at 12:11 PM " ...The resident complaints(sp) of fall 2 days ago, no injury sustained as perpatient report and on assessment no physical injury noted on examination ..."

-[Incident Note] 09/19/22 at 2:41 "A follow-up was

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F 607 | F 607

Continued From page 55

made with resident regarding complain of left shoulder pain on 9/16/2022, after returning from LOA. When asked what happened, resident stated that she tripped on a brick while coming down the hill located in front of the facility entrance and landed on her right knee and then fell on her left side. Upon assessment, denies hitting her head, denied that left shoulder was what was hurting her, right knee slightly swollen compared to left knee. Left back/flank area notedwith bruising/discoloration measuring 1.5 cm (centimeters) x (times) 1 cm ...enquired as to what she was wearing in terms of footwear and she showed by a slipper/slide on which is inappropriate for outside terrain ...DNP (Doctor Nurse Practitioner) made aware and she gave anorder for thoracic/lumbar x-ray (x-radiation) alongside right knee x-ray to rule out fracture ..."

-[Care Plan] date initiated 09/19/22
Focus-"[Resident #237] had a fall incident on 9/16/22 which was reported on 9/19/22"

During a face-to-face interview conducted on 03/10/23 at 1:22 PM, Employee #3 (Director of Nursing) stated that there was a delay in submitting the fall incident to the Department of Health, and the involved employee was educated.

Cross Reference 22B DCMR sect. 3232.2

F 609 SS=D | F 609

Reporting of Alleged Violations
CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facilitymust:

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F 609	Continued From page 56 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result inserious bodily injury, or not later than 24 hours if the events that cause the allegation do not involveabuse and do not result in serious bodily injury, tothe administrator of the facility and to other officials (including to the State Survey Agency andadult protective services where state law providesfor jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials inaccordance with State law, including to the StateSurvey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidencedby: Based on record reviews and staff interviews forone (1) of 105 sampled residents, facility staff failed to report an injury of an unknown source timely to the State Agency per its policies and procedures. (Resident #237) The findings included: A review of the facility's policy titled "Abuse Neglect and Exploitation" with a revision date of09/20/22, documented " ...An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of	F 609	1.Resident # 237 currently resides in thefacility and had no ill effects noted at this time. 2.The Director of nursing/designee will review incidents of unknown source in the last 30-days on 5/19/23 to assure that the incident was reported to the State agency per protocol. There were no reported findings. 3.The Educator/designee will in-service Administration and licensed professional nursing staff on assuring that alleged violations involving abuse,neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property are reported to the Administrator, state agency and required agencies within specified timeframes. 3.The Director of Nursing/designee will review incidents of unknown source to assure that the incident was reported to the State agency per protocol. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	06/09/2023

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F 609	Continued From page 57 abuse, neglect or exploitation occur. Written procedures for investigations include ...focusing the investigation on determining if abuse, neglect, exploitation and or mistreatment has occurred, the extent and cause and providing complete andthorough documentation of the investigation ...Reporting/Response The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency and to all other required agencies ...withinspecified timeframes ..." Resident #237 was admitted to the facility on 12/03/21 with multiple diagnoses that included thefollowing: Asthma, Heart Failure Unspecified, andOther Abnormalities of Gait and Mobility. A review of the medical record revealed a Quarterly Minimum Data Set (MDS) assessmentdated 09/08/22, showing that the facility staff coded the resident as cognitively intact, needingsupervision and a one-person physical assist forlocomotion on and off the unit, and having no impairment in the upper or lower extremity. A nursing progress note dated 09/16/22 at 9:29 PM documented, "reident (sp) returned from LOA(Leave of Absence) around 9 pm. upon arrival pt (patient) alert and oriented X (times) 4 (person, place, time, situation) but appeared to be tiered (sp) (tired). she complained left shoulder pain. Pt ststed (sp) (stated) "I tripped on something on myway back to the facility and stained my left shoulder while I tried to prevent from falling," RN (registered nurse) assessed resident and no signof dislocation or fracture noted. Possible muscle strain due to putting her weight on her arm and her walker. Pt stated only her left knee touch the floor. No injury to bilateral knees. Pain medication	F 609		

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F 609	Continued From page 58	F 609		

administered and encourage to take rest ... SBP (systolic blood pressure) elevated 171. possibly because resident did not take her BP (blood pressure) medication on time ..."

Further review of the medical record revealed a nursing progress note dated 09/16/22 at 11:22 PM documenting, "BP (blood pressure) rechecked and it was 150/85. Resident her painis almost the same 5/10. we will continue to monitor resident."

A Situation Background Assessment Recommendation (SBAR) -Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Note dated 09/19/22 at 12:11 PM documented, " ...The resident complaints (sp) of fall 2 days ago, no injury sustained as per patient report and on assessment no physical injury noted on examination ..."

An Incident Note dated 09/19/22 at 2:41 documented "A follow-up was made with residentregarding complain of left shoulder pain on 9/16/2022, after returning from LOA. When askedwhat happened, resident stated that she tripped on a brick while coming down the hill located in front of the facility entrance and landed on her right knee and then fell on her left side. Upon assessment, denies hitting her head, denied thatleft shoulder was what was hurting her, right kneeslightly swollen compared to left knee. Left back/flank area noted with bruising/discoloration measuring 1.5 cm (centimeters) x (times) 1 cm ...enquired as to what she was wearing in terms of footwear and she showed by a slipper/slide onwhich is inappropriate for outside terrain ...DNP (Doctor Nurse Practitioner) made aware and shegave an order for thoracic/lumbar x-ray

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F 609	Continued From page 59 (x-radiation) alongside right knee x-ray to rule out fracture ..." A care plan initiated on 09/19/22 contained a Focus of-"[Resident #237] had a fall incident on9/16/22 which was reported on 9/19/22" The medical record lacked documented evidencethat the facility followed its policies and procedures to investigate and report Resident #237's fall to the State Agency. During a face-to-face interview conducted on 03/10/23 at 1:22 PM, Employee #3 (Director of Nursing) stated that there was a delay in submitting the fall incident to the Department of Health, and the involved employee was educated. Cross Reference 22B DCMR 3232.4 Preparation	F 609		
F 624 SS=L	for Safe/Orderly Transfer/DschrgCFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer ordischarge. A facility must provide and document sufficient preparation and orientation to residents to ensuresafe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidencedby: Based on review of medical records, administrative records, facility documentation/policies, and family and staff interviews, for three (3) of 3 sampled discharged residents, the facility's staff failed to ensure residents were safely discharged as evidenced by	F 624	1.R585 and R586 were discharged on1/11/23 and 12/27/22 respectively. R332 was discharged on 12/30/2022. E4 was educated on policy and procedures related to discharge meds. 2.One resident was discharged in the last 7 days and ensured that resident and/or their representative had the correct prescriptions per the provider's order, special instructions for medications for potential complications, side effects and drug interactions. The information will be shared via the medication administration instructions per the titled form, "Drug Information Sheets"from our electronic health record software. Findings indicated that discharge medications and information were provided to resident/resident representatives.	06/09/2023

3.Licensed professional nursing staff. were in-serviced on 5/23/23 by educator or designee on providing written instructions on how to safely administer medications by sending residents home with the physician prescriptions, orders, medication administration instructions via the "Drug Information Sheets".

4.QA consultant/designee will audit residents discharged to home to assure that written instructions on how to safely administer medications were provided. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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not providing Residents #332, #585, and #586with written instructions for discharge medications. In addition, Resident #332 was discharged with Resident #27's Lisinopril (hypertensive medication). These failures havethe potential to affect any resident who is discharged from the facility.

Due to these failures, an Immediate Jeopardy situation was identified on February 17, 2023, at 4:17 PM. The facility submitted a Plan of Action tothe survey team that was on onsite at 2:21 AM onFebruary 18, 2023, and the plan was accepted. The survey team returned on February 21, 2023,to validate the facility's plan, and the Immediate Jeopardy was lifted on February 21, 2023, at 5:45PM. After removal of the immediacy, the deficientpractice remained at a potential for harm and thescope and severity was lowered to a F.

Findings included:

Review of a policy titled, Discharge Summary dated 02/01/22, documented, "A final summary ofthe resident's status which includes ... for residents discharged to their home, the medical record should contain documentation that writtendischarge instruction were given to the resident and if applicable, the resident representative.
These instructions must be discussed with the resident and resident representative and conveyed in language and manner they will understand ..."

Review of Resident #332's medical record revealed Resident #332 was discharged from alocal hospital to the facility on 12/21/22. The discharge summary revealed diagnoses, including Hypertension, Heart Failure, and

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F 624	Continued From page 61 Pulmonary Embolism. Discharge medications included acetaminophen, apixaban, atorvastatin, cyclobenzaprine, furosemide, hydralazine, lidocaine topical, losartan, melatonin, metoprolol,pregabalin, and sennosides-docusate. The discharge summary also noted the following allergies: "Active and Proposed Allergies Only)" aspirin and metformin. Resident #332's monthly Physician Order Sheetfor 12/21/22 to 12/30/22 documented the following medications were ordered: -Atorvastatin Calcium (statin) 40 mg (milligrams)give 1 tablet by mouth at bedtime. -Eliquis (anticoagulant) 0.5 mg give 1 tablet by mouth two times a day. -Furosemide (diuretic) 40 mg give 1 tablet bymouth one time a day. -Hydralazine Hydrochloride (vasodilator) 50 mggive 1 tablet by mouth three times a day. -Lidocaine Patch (local anesthesia) 5% apply toleft flank area topically every dayshift. -Losartan Potassium (angiotensin receptor blocker)25 mg give 1 tablet by mouth one time aday. -Melatonin (biogenic amine) Capsule 5 mg give 1 capsule by mouth at bedtime. -Metoprolol Succinate (beta blocker) Extended Release 24 hour 50 mg give 1 tablet one time aday. -Pregabalin (anticonvulsants) Capsule 25 mg give 1 capsule by mouth one time a day. -Senna Plus (stimulant laxative) Tablet 8.6-50 mggive 1 tablet by mouth two times a day. -Cyclobenzaprine Hydrochloride (skeletal muscle relaxants) 10 mg give 0.5 tablet by mouth every 8hours as needed...	F 624		

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F 624	Continued From page 62 -Robitussin (antitussive) 12 hour Cough Suspension Extended Release 30 mg/ml (milliliters) give 5mg/ml by mouth every 6 hoursas needed... In addition, the physician's order sheet documented the resident had the followingallergies: Aspirin and Metformin. A History and Physical assessment dated 12/23/22 documented that Resident #322 had thefollowing allergies: "Metformin and Aspirin". A 5-day minimum data set (MDS) assessment dated 12/28/22 showed Resident #332's Brief Interview for Mental Status (Bims) summary score was "15", indicating the resident had an intact cognitive status. A 12/29/22 at 3:08 PM Nurse Practitioner Note read, "Ask to make patient's prescriptions and Rx(medical prescription) for outpatient PT/OT (physical therapy/occupational therapy) @ (at) [Rehabilitation Hospital's name]. by social services. As per Social service, patient is going to[be] discharge home on 12/30/22. Prescriptions for 30-day medication supply and RX for outpatient PT/OT sent to 2N (north) unit secretaryemail." A Discharge Nursing Summary Note dated 12/30/22 at 12:59 PM read, "Resident dischargedhome from the facility at 10:30 am. She is alert and oriented X4 (person, place, time, and situation). Oxygenation saturation at 98% on RA (room air), blood pressure 122/69, respiration 18,pulse 85, temperature 98.1 ...She ambulates with a walker. She left with her leftover medication in the chart. After care instructions were provided	F 624		

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and explained. She verbalized complete understanding ... She is self-responsible."

The facility's Discharge Planning/Summary Process dated 12/29/22 at 1:07 PM, included, " ...Level of Consciousness - Alert/fully conscious.
Orientation - person, place, time, situation ... Nursing Instructions Regarding Discharge - [Resident's name] has been educated on her discharge instructions. [Pro-noun] verbalized complete understanding ...
Medication Instructions - Printed/written directions have beenprovided for each of the medications being takenout of the facility. "Yes". However, continued review of the medical record lacked documented evidence of the printed/written directions providedto the resident or resident's family.

Review of the facility's investigation, revealed the following:
The discharging nurse's statement dated 01/04/23 documented, " ... I explained to [residentand family] who were at the bedside ... the aftercare instructions which include (sp) the time and when to take each medication and treatmentper doctor's orders. I also her gave [resident's name] all her leftover medications that were in themedication cart per protocol. [Resident's name] and her daughter verbalized understanding of discharge instructions. [Resident's name] told meshe used to work here ... as a RN. I then provided her with 2 copies of her discharge instructions and told her to go thoroughly throughinstructions, read it and if she has any questions,I'll provide an answer ...I went [back] to her room and asked ... if they had any questions. [Resident's name] said, "No" ..."

A Letter from the Administrator to Resident #332's

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F 624	Continued From page 64 family dated 01/04/23 read, "On January 23, 2023, your [pro-noun] made us aware of a protected health information data breach involving a resident at Capitol City. It seems that when [Resident] was discharged from the facility provided another resident's medication card along with [Resident] medication cards. I apologize for the inconvenience. Please return the medication card to the facility, as it is the property of another resident. If returning to the facility poses a hardship, please shred the portionof the medication card which details the resident name and medication and dispose of the medication ... Again, my apologies for the inconvenience." Review of complaint received by the State Agency dated 01/26/23 (DC- 11567) read, "On December 13, 2022 ... [Resident #332] was released from the nursing home on December 30[2022], She was given medication (lisinopril) thathad been prescribed for someone else (Resident#27). She had an immediate and sever allergic reaction to this medicine ....[Resident #332] still remains in the hospital and was in a comatose state for at least a week ....In addition, ... it was noted in [pro-noun] medical file, that under NO circumstances should [pro-noun] be given this medicine [lisinopril]. [Resident #332] was immediately rushed to [a local hospital]. When I notified the staff at the nursing home of their mistake and [Resident #322's] resultant reaction instead of an apology or show remorse, Iwas told that it was my responsibility to check themedication and make sure it was not [Resident #322's] and they were not accountable .... still remains in the hospital and was in a comatosestate for at least a week ...."	F 624		

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F 624	Continued From page 65 During a telephone interview on 02/10/23 startingat 1:30 PM, Resident #332's family members stated that the resident was provided another resident's "Lisinopril" medication when the resident was discharged on 12/30/22. They reported that when they went to pick up the resident for discharge, Employee #4 (LPN; Discharging Nurse) did not meet with them. Instead, the employee gave them paperwork to sign and provided them with a bag of Resident #332's medications. The family members reported, after returning home, they noticed the resident's tongue was swollen after the resident asked if her tongue was swollen. They took Resident #332 to the hospital immediately and was told by hospital staff that she was having an allergic reaction to Lisinopril. The resident's familystated she "ended up in ICU, on a ventilator, and in a coma for one week" after taking the Lisinopril. The family was asked who administered the resident's medication while at home? They stated that the resident administeredher own medication like she did prior to being admitted to the facility. In addition, while speakingwith the family members, the resident could be heard in the background answering questions that family members were asking. The surveyor asked if she could speak with the resident, but the resident refused to talk with the surveyor. During a telephone interview on 02/10/23 at 5:17PM, Employee #4 (LPN) stated that he discharged Resident #332 home with family in December of 2022. The employee stated he verbally explained the discharge instructions including the medication and times when to take the medications to the resident and resident's family. The only written instruction he provided formedication was a copy of the prescriptions.	F 624		

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F 624	Continued From page 66 Further interview revealed that Employee #4 gave Resident #332 all her "left-over medications" in the cart. The employee was asked if he used the prescriptions to check the medications that he gave the family. He stated, "Yes, we went one-by-one. The employee was then asked, if hewent one-by-one with the prescriptions and medications, how did Resident #332 get another resident's (Resident #27) lisinopril? He stated, "I can't explain. The medication was stuck to one ofher own medications. My guess it was stuck to her medicine." Also, the employee said it was thefacility's protocol to provide resident's being discharged with their medication from the medication cart. The employee was asked if he was aware of the resident's allergies? He said, "I can't remember any allergies at this time." During a face-to-face interview on 02/10/23 starting at approximately 5:30 PM, Employee #3 (DON) stated that Employee #4 gave Resident #332 another resident's Lisinopril. Additionally, the DON reported Employee #4 failed to follow the discharge protocol by not asking the supervisor to be involved in discharging the resident. The employee also said the resident should have been provided with written instructionon how to safely administer the prescribed discharge medications at home During a face-to-face interview on 02/13/23 at 3:39 PM, Employee #1 (Administrator) stated thatthe discharging nurse discharged Resident #332 with Lisinopril that belonged to another resident. He reported that during the first week in January the family made Employee #5 (Quality Assurance) aware that they had another resident's medication card (blister pack) for Lisinopril. Employee #1 stated that he spoke withthe family about their concerns and gave them a letter that outlined how to destroy personal health	F 624		

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F 624	Continued From page 67 information and medication. When asked, if he was aware the resident was intubated and in ICU,he stated, "I don't recall if she was in ICU or on aventilator." During a telephone interview on 02/13/23 at 2:26PM, Employee #10 (Medical Director/Resident's #332 Primary Physician) stated that he did not order the resident Lisinopril during her stay at thefacility. The Medical Director stated that he was informed that the discharging nurse mixed up another resident's Lisinopril medication with Resident #332's medication. Additionally, the Medical Director stated he was not aware of the resident having an allergy to Lisinopril. He statedhe gets allergy information from hospital records. During a face-to-face interview on 02/14/23 at 11:55 AM, Employee #5 (Quality Assurance) stated that on January 2, 2023, Resident #332's two daughters came to the facility and made her aware that the resident was discharged with another resident's Lisinopril. They said the resident was allergic to Lisinopril and they believeshe took it. They said that the resident was hospitalized because was she was allergic Lisinopril. Additionally, Employee #5 stated, "They (resident's daughters) said [pro-noun] wasvery ill and they showed me a picture of her and she looked like she was intubated." Additionally, the employee stated that the family showed her the blister packet that belonged to the other resident, and it looked like three (3) of 30 pills were missing from the blister pack. 2. Resident #586 was admitted to the facility on 02/05/20 with diagnoses that included: Metabolic Encephalopathy, Hyperlipidemia, Acute Kidney Failure, Fracture of Right Femur, and Cognitive Communication Deficit.	F 624		

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F 624	Continued From page 68 Review of the resident's medical record revealeda Quarterly Minimum Data Set (MDS) assessment dated 11/8/22 which included a BriefInterview for Mental Status (Bims) summary score of "12", indicating the resident was cognitively intact. A Nursing Progress Note dated 12/27/22 at 9:30 AM read, "Resident went home with an escort viaUber, a copy of discharge summary was handedto him with all his belongings ..." A Discharge Planning Summary/Process dated 12/27/22 at 1:24 PM documented, " ...Resident isalert and ready to be discharged all due meds given and well tolerated, teaching done and resident understand how to take his meds (medication) ..." Further review of Resident #586's medical record showed there was no documented evidence thatthe resident was provided written instructions onhow to safely administer the medications that were given to take home at discharge. During a face-to-face interview on 02/16/23 at 03:30 PM, Employee #3 (DON)was asked aboutthe facility's policy pertaining to resident discharges, instructions, and medications. Employee #3 stated that the resident should receive discharge instructions in writing which includes the medication list and any special instruction for medication i.e. taking blood pressure before taking antihypertensive medication. 3. Resident #585 was admitted to the facility on 12/01/22 with diagnoses that included: Cognitive	F 624		

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F 624	Continued From page 69 Communication Deficit, Cerebral Infarction, Dysphagia, Hypertensive Urgency, and Muscle Weakness, Review of Resident #585's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 12/08/22 which included a Brief Interview for Mental Status (Bims) summaryscore of "03", indicating the resident was severelyimpaired. The Discharge Planning Summary/Process] dated 01/11/23 at 11:27 AM documented ..."Resident was educated that pharmacy will send [pronoun] medication to [pronoun] house, and how to take it too ...Required education & acknowledgement of education: Medication Instructions: Printed/written directions provided for each of the medications being taken out of thefacility ...a) "Yes" ..." A Nursing Progress Note dated 01/11/2023 at 4:32 PM read, "Resident was discharged homethis morning at 10:45am in stable condition, tolerated due meds, was discharged with [pronoun] belongings, discharge papers, pharmacy will send [pronoun] medication to [pronoun] house, left with RR (responsible representative) who signed the discharge papers." Further review of the resident's medical record showed there was no documented evidence thatthe resident's representative was provided with written instructions on how to safely administer the medications ordered to be taken at home at time of discharge. During a face-to-face interview on 02/16/23 at	F 624		

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F 624	Continued From page 70 03:30 PM, Employee #3 (DON) was asked aboutthe facility policy pertaining to resident discharges, instructions, and medications. Employee #3 stated that the resident should receive discharge instructions in writing which includes the medication list ..." Based on these findings, on February 17, 2023, at 4:17 PM, an Immediate Jeopardy (IJ)-"J" situation was identified. On February 18, 2023, at2:21 AM, the facility's Clinical Executive Director provided a corrective action plan to the State Agency Survey Team that was accepted. The plan included: -Resident #1 discharged from the facility on 12/30/22. -Resident #9 discharged from the facility on 1/11/23. -Resident #10 discharged from the facility on 12/27/22. -The facility didn't receive any reports from the residents who discharged on 1/11/23 to 2/17/23 regarding their medications and/or discharge instructions. -The Director of Nursing or other clinical leaders will ensure residents who are scheduled for discharges 2/18-2/20/23 will be at audited to ensure the resident and/or their representative have the correct prescriptions per the provider's order, special instructions for medications for potential complications, side effects and drug interactions. The information will be shared via the medication administration instructions per thetitled form, "Drug Information Sheets" from our	F 624		

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F 624	Continued From page 71 electronic health record software. -The discharging nurse will be responsible to ensure that resident teaching regarding medication administration is shared in a manner that is easily understood using the provided, "Drug Information Sheets." The discharging nursewill ask the family to express their understanding and/or questions after receiving the teaching via the provided "Drug Information Sheets." Audits will be on-going and will be completed by the clinical leaders which will include; but not limited to, the Director of Nursing, the Assistant Directorsof Nursing, Unit Managers and other licensed nursing personnel per the auditing schedule. Audits will be completed on the residents' discharge date; including but not limited to, the weekends and holidays. Education -The Nursing Administration, licensed nurses responsible for discharging residents and social service personnel; including but not limited to, the Director of Discharge Planning, will be educated on the revised discharge protocol which will be to: 1. Ensure the resident and/or their representativehas the correct medication prescriptions per the providers' orders. 2. Provide the resident and/or their representativewith the physician orders. 3. Give their medication administration instructions to the resident and/or their representative per the "Drug Information Sheet"from Point Click Care. 4. The discharging nurse will ensure teaching is done in a manner that the resident and/or their representative will easily understand. The discharging nurse will ask the resident and/or their representative if there's any questions about	F 624		

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F 624	Continued From page 72 their discharge medication per their prescriptions. The discharging nurse will attempt to answer their questions to the best of their ability. The providerwill be contacted if the nurse's answers aren't sufficient. 5. Education was initiated on 1/25/23 and ongoingto the licensed nurses about the facility's discharge protocol revisions. The discharge protocol summary noted, "Nurses must review the discharge instructions to ensure follow up information such as appointments, wound care/wound care supplies, current medication list with administration times, acknowledgement of discharge instructions with wet signatures." Discharge protocol will be revised and education given to the licensed nurses to note the systematic changes as of 2/17/23. 6. Education to weekend staff to be provided by either shift supervisor, staff development, a clinical leader and/or the Director of Nursing. Education will be provided either in-person or via phone calls and/or the facility's electronic SMS communication tool. The nursing staff who worksin the facility on 2/18, 2/19 and 2/20 will have onsite in-servicing to reinforce the education senton 2/17/23 via SMS communication tool. There are no scheduled discharged 2/18, 2/19 or 2/20/23. Staff will not be allowed to work until they have received the required training. System Change -The facility will revise our discharge practices viaour discharge protocol that will only send residents home with the physician prescriptions, orders, medication administration instructions via the "Drug Information Sheets" which includes thecontent that the licensed nurse can use to provideeasily understood teaching. If questions and/or	F 624		

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F 624	Continued From page 73 concerns arise, the nurse will attempt to answerthe questions. If the answers are not sufficient, the provider will be contacted. Monitoring -The Director of Nursing or designee will audit all discharging residents to ensure that they have the correct medication prescriptions, physician orders, medication administration instructions via the "Drug Information Sheets", ensure that resident teaching regarding medication administration is shared in an easily understood manner and questions are answered by the nurseand/or provider weekly x 4, then monthly x 3. Results of the audits will be submitted to theQuality Assurance and Performance Committee. The Committee will determine the need for further and/or action plans. Date of compliance: 2/23/23 Verification of the removal of the immediacy was performed by the survey team onsite on February21, 2023, at 5:45 PM Cross reference 22B DCMR sect. 3270.3	F 624		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the residentthat meet professional standards of quality care.	F 655		

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F 655	Continued From page 74 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baselinecare plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) ofthis section). §483.21(a)(3) The facility must provide the resident and their representative with a summaryof the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel actingon behalf of the facility. (iv) Any updated information based on the detailsof the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, andstaff interview, for one (1) of 104 sampled residents, the facility's staff failed to develop a	F 655	1.Resident #74 was discharged from facility on 3/28/2023. 2.Social work director or designee will review any new admissions/readmissions in the last 7 days to ensure that a baseline care plan was developed within 48hrs of admission/readmission. A total of 5 admissions/readmissions were reviewed. One resident wasn't applicable due to being discharged in less than 48hrs and one resident BCP completed upon identification. All residents who are admissions/readmissions have the potential to be affected. 3. The Educator or designee will in-service interdisciplinary team member starting on 5/22/23 to assure that a baseline care plan must be developed within 48hrs of admissions/readmissions. 4.The QA consultant or designee will review admissions/readmissions to ensure that a baseline care plan was developed within 48hrs. Audits will be completed weekly x4 and then monthly x3. All issues will be corrected immediately. The results of the audits will be submitted to the QA and performance committee. Date of compliance 6/9/2023.	6/9/2023

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F 655	Continued From page 75 baseline care plan for Resident #74.The finding included: Resident #74 was admitted on 11/23/22 with multiple diagnoses including Anemia Muscle Weakness, and Dysphagia. A review of the resident's medical record including progress notes, care plans and assessments lacked documented evidence that staff developed a baseline care plan for Resident#74. A review of a document titled, "Interdisciplinary Care Conferences" lacked documented evidencea care plan conference meeting was held 48 hours after Resident #74's admission date of 11/28/22. According to the document, the first care plan conference was held on 01/31/23, andthe resident's daughter signed the document to indicate she attended. During an interview with Resident #74's daughter (responsible party) on 2/13/23 at 5:00 PM, she reported that the facility staff did not inform her what care was being provided for her mother during her first week of admission (admitted on 11/28/22). When asked, did she have a baselinecare meeting within 48 hours of admission, she said "No, my first care plan meeting was held on01/31/23." During a face-to-face interview on 03/10/23 at approximately 5:00 PM, Employee #27 (Assistant Director of Nursing) stated that she did not see inthe record that a base line plan was developed for the resident's admission on 11/28/22.	F 655		

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F 655	Continued From page 76 Cross reference 22B 3211.1(a)	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with theresident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan mustdescribe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being asrequired under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with thefindings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		

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F 656	Continued From page 77 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive careplan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arrangedby the facility, as outlined by the comprehensivecare plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, facility staff failed to develop/implement care plans for (2) of 105 sampled residents. (Residents #131 and #53) The findings included: 1. Facility staff failed to develop a care plan that addressed Resident #131's short-term memory deficit. Resident #131 was admitted to the facility on 02/03/17 with multiple diagnoses that included thefollowing: Dementia, Bipolar Disorder, and Alcohol Abuse. A Review of Resident #131's Quarterly Minimum Data Set (MDS) Assessment dated 07/24/22 revealed that the facility staff coded the residentas having a moderate cognitive impairment and no impairment in the upper or lower extremity. The facility staff coded the resident as having no behavioral symptoms. A Psychological Services Supportive Care progress note dated 07/28/22 at 8:21 AM documented, " ...Met with patient today at the	F 656	1. Residents #131, #53 currently reside in the facility. No ill effects noted. Resident #131's care plan was initiated on 05/11/2023 to address his short term memory deficit that affected the resident's ability to remember instructions. Resident #53's polypharmacy careplan was initiated on 3/3/23 to address resident's potential for adverse reactions related to taking nine or more medications 2. The Unit manager or designee will review current residents in the facility to ensure that a care plan is developed for those with short term memory deficit and who are prescribed nine or more medications. Residents who have potential to be affected are those with short term memory deficit and those who are on 9 or more medications. 3. The Nurse educator or designee will in service licensed professional nurses and social service team to initiate a care plan for residents who have short term memory deficit and those who have prescribed nine or more medications. 4. The unit manager or designee will audit 20% of residents with short term memory deficit to ensure that a care plan is developed. Any identified issues were addressed and care plan initiated. The unit manager or designee will audit 20% of residents who are prescribed nine or more medications to ensure that a care plan is developed. Identified issues were identified and addressed right away by initiating a care plan.	6/9/2023

			Audits will be completed weekly x4 and then monthly x3. Results of the audits will be submitted to the QA and performance committee. Date of compliance 6/9/2023.	

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F 656	Continued From page 78	F 656		

request of the facility after he was assaulted by another resident ...Asked patient what happened between he and the other resident. Patient stated" I don't remember anything" Patient doesn't remembe3r (sp) being taken to the ED for treatment or anything else that happened ..."

A review of a Facility Reported Incident (FRI) submitted to the state agency on 01/19/23 documented the following: "Report received that resident [Resident #131] was involved in a physical altercation with resident [Resident #169]today at 2:50 pm, as he entered the first-floor dining room. Allegedly [Resident #131] was hit by[Resident #169] in the face and a fight ensued ..."

A nursing progress note dated 01/19/23 at 7:39 PM documented, " ...[Resident #131] was seen tofollow up regarding the incident that was reportedwhile in the smoking patio. Mr. [Resident #131] don't have any recollection of any involvement inthe smoking patio. Assessment was made, no any bruise or redness on his hand, no sign of anyinjury noted, he stated that he is fine ..."

A review of a Facility Reported Incident (FRI) submitted to the state agency on 02/16/23 documented the following: "Around 10.49 am thismorning, writer heard loud voices and went toward the voices. On approaching the first-floor dining room writer observed [Resident #131] astride [Resident #169] ...on the floor near the vending machine towards the rear of dining room.The residents were separated. There was no apparent injury ..."

[Care Plan] initiated on 02/16/23, Focus: "[Resident #131] had a resident-to-resident interaction with [Resident #169] while in the first

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F 656	Continued From page 79 dining room" Interventions: "Emphasize to [Resident #131} to stay away from [Resident #169], Encourage [Resident #131] to report issueand concern to staff .... Encourage to refrain from being aggressive towards other residents and report any disagreement he has with other residents to staff ......" A review of the comprehensive care plan that was initiated on 02/16/23 lacked documented evidence that the facility staff developed a care plan to address the resident's short-term memorydeficit that affected the resident's ability to remember to come to staff to prevent an altercation with peers or remember any of the staff's instructions. During a face-to-face interview conducted on 02/28/23 at approximately 1:30 PM, Employee #18 (Unit Manager 3 South) stated that Resident#131 has no short-term memory and after each incident she assessed the resident, and he had no memory of the encounter with a peer that is why she used the words encourage and emphasize instead of educate in the care plan. 2. Facility staff failed to implement a polypharmacy care plan Resident #53 who was prescribed nine or more medications. Review of Resident #53's medical record showedthat the Resident was admitted to the facility on 12/11/20 with diagnoses including: Major Depressive Disorder, Paranoid Schizophrenia, Bipolar Disorder, Dementia, Epilepsy, PeripheralVascular Disease, and Generalized Muscle Weakness.	F 656		

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F 656	Continued From page 80 Resident #53's medical record revealed the following physician's orders: -Physician's Order dated 12/16/20 directed: "Tylenol Tablet 325 mg (Acetominophen) Give 2(two) tablet(s) by mouth two times a day for legpain. -Physician's Order dated 02/08/21 directed: "Losartan Potassium Tablet 100 mg. Give one tablet by mouth one time a day for HTN (Hypertension). Hold for SBP (systolic blood pressure) <110 and DBP (diastolic blood pressure) < 60." -Physician's Order dated 03/30/21 read: "Labetalol HCL (hydrochloride) Tablet 300 mg, Give 300 mg by mouth two times a day for HTN(Hypertension). Hold for SBP<110 and DBP < 60." -Physician's Order dated 04/27/21 directed: "Elliquis Tablet 2.5 mg (Apixaban), Give 1 (one)tablet by mouth two times a day for DVT (deepvein thrombosis) prophylaxis." -Physician's Order dated 05/18/21 read: "Diltiazem HCL ER Coated Beads Capsule Extended-Release 24 hour 360 mg, Give 1 (one)capsule by mouth one time a day for HTN. Hold ifSBP<110 or DBP < 60." -Physician's Order dated 09/14/21 directed: "Cardura Tablet 4 mg. Give 1 (one) tablet by mouth one time a day for Hypertension. Hold meds for SBP <110 or DBP < 60." -Physician's Order dated 09/14/21 directed: "Depakote Tablet Delayed-Release 500 mg, Give	F 656		

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F 656	Continued From page 81 1 (one) tablet by mouth two times a day for Mood Disorder." -Physician's Order dated 08/31/22 directed: "Aricept Tablet 10 mg (Donepezil HCL), Give 1(one) tablet by mouth at bedtime for Dementia." -Physician's Order dated 10/04/22 directed: "Haloperidol Decanoate Solution 100 mg/ml. Inject 100 mg intramuscularly every evening shiftstarting on the 8th and ending on the 8th every month for Schizophrenia." Review of an annual Minimum Data Set (MDS) assessment dated 12/15/22 documented a Brief Interview for Mental Status (BIMS) summary score of "05", indicating that the Resident had severely impaired cognition. In addition, the Resident was noted as displaying fluctuating inattention and was administered an anticoagulant and an opioid within the last sevendays of the assessment. Review of an Annual History and Physical Assessment for Resident #53 dated 12/29/22 at 1:00 PM revealed: "Current Medications: Losartan Potassium Tablet 100 mg (milligrams), Labetalol HCL (hydrochloride) Tablet 300 mg, Elliquis Tablet 2.5 mg, Diltiazem HCL ER (extended-release) Coated Beads Capsule Extended-Release 24 hour 360 mg, Cardura Tablet 4 mg, Tramadol HCL Tablet 50 mg, Depakote Tablet Delayed-Release 500 mg, Aricept Tablet 10 mg, and Haloperidol DecanoateSolution 100 mg/ml (milligrams/milliliter)..." Review of resident #53's comprehensive patient-centered care plan lacked documentedevidence that facility staff included a	F 656		

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F 656	Continued From page 82 polypharmacy care plan to address the Resident's potential for adverse reactions related to taking nine or more routine medications. During a face-to-face interview on 03/09/23 at 1:05 PM, Employee #38 (1 North Unit Manager) stated that the nurse managers were responsiblefor updating the Residents' care plans. After reviewing Resident #53's comprehensive care plan, the Employee acknowledged that there wasno polypharmacy care plan to address the Resident's potential risks associated with taking nine or more routine medications. Cross reference 22B DCMR sect. 3210.4(a)Care	F 656		
F 657 SS=E	Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan mustbe- (i) Developed within 7 days after completion ofthe comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation ofthe resident and the resident's representative(s).An explanation must be included in a resident's medical record if the participation of the residentand their resident representative is determined not practicable for the development of the resident's care plan.	F 657	1.R29, R150 and R60 currently reside in the facility. No ill effects noted. R29 care conference scheduled for 05/17/2023 R150 had a care conference meeting on 03/30/2023. R60 had a care conference meeting on 4/18/23. 2.The Director of social service or designee will review current residents who had MDS completed in the last 14 days to ensure that a quarterly care planning conference was held for each resident, and if they haven't then one will be scheduled and executed. All residents have the potential to be affected. Findings showed that several residents were missing a care conference and a care conference will be scheduled and residents and representatives will be notified.	06/09/2023

The Director of social service or designee willin
rvice the social service staff to ensure that acare
anning conference is being done quarterlyfor all
sidents per requirement.

4.The Director of social service or designee will audit residents who are scheduled for MDS assessment to ensure that a care planning conference is scheduled and completed quarterly. Audits will be conducted weekly x4 and monthly x3 until date of compliance. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.

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F 657	Continued From page 83 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needsor as requested by the resident. (iii)Reviewed and revised by the interdisciplinaryteam after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidencedby: Based on record review and staff interviews, for (3) of 105 sampled residents, the Inter Disciplinary Team (IDT) failed to conduct quarterly care planning conferences for Residents#29, #150, and #60. 1. Resident #29 was admitted to the facility on 05/03/20 with multiple diagnoses that included the following: Schizophrenia, Acquired Absence of Right Leg Below Knee, and Acute Kidney Failure. A review of the medical record revealed the facesheet noting Resident #29 was his/her own responsible party. The following care plan meeting notes werenoted: -02/10/22 at 11:17 AM, "IDT (Interdisciplinary Team) reviewed plan of care, goals and interventions up to date for [Resident #29] Representative (...) invited but unable to attend." -04/14/22 at 1:19 PM, "IDT reviewed plan of care goals and interventions up to date with [Resident#29]. [Resident #29] is alert and oriented to self, place and time with intermittent confusion. He is incontinent of both bladder and bowel he needs 1staff limit assist with ADL (Activities of Daily Living) care and transfers. He uses a manual	F 657		

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F 657	Continued From page 84 wheelchair to move around independently. Skin remains intact. He remains a full code, currentlydoes not have any placement in the community ..." -04/14/22 at 1:37 PM, "Family joined IDT meetingvia phone" A review of the Quarterly Minimum Data Set (MDS) assessment dated 02/01/23, showed thatthe facility staff coded the resident as having severe cognitive impairment. A subsequent Care Plan Meeting Note dated 02/09/23 at 1:55 PM noted, "IDT met and reviewed plan of care, goals and interventions ..." During an observation and face-to-face interview conducted on 02/22/23 at approximately 1:15 PM, Resident #29 stated that he just wants to go home, and he is not sure who his social worker is. A review of the medical record revealed that therewas no documented evidence of there being any quarterly interdisciplinary team meetings from 04/15/22 until 02/08/23. During a face-to-face interview conducted on 03/09/23 at approximately 3:00 PM, Employee #50 (Social Worker) stated that she just had an Interdisciplinary team meeting with Resident #29and she cannot explain why they were not donequarterly prior to 02/09/23 because she just started working at the facility. 2. Resident #150 was admitted to the facility on 02/22/18, with multiple diagnoses that includedthe following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left	F 657		

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F 657	Continued From page 85 Non-Dominant Side, and Unspecified Dementia. A review of the medical record revealed the facesheet noting Resident #150 is his own responsible party. A care plan initiated 02/28/18, documented the following: Focus- "Resident's term stay is indefinite until further notice;" Goal- "Residents' discharge status will beassessed quarterly." Interventions- "Writer will assist resident with obtaining (...) services and durable medical equipment upon discharge if needed." A Care Plan Meeting Note dated 09/15/22, at 3:55PM documented, "IDT meeting held today with all the discipline and resident participate himself. Resident is alert and oriented X (times) 3 (personplace time) is able to make his own decision ...Remain on long term care. Continue plan of care." A review of the Annual Minimum Data Set (MDS) assessment dated 12/18/22 showed that the facility staff coded Resident #150 as having moderately impaired cognition. During a face-to-face interview was conducted on 02/22/23 at approximately 12:30 PM Resident #150 stated that he has not met with a social worker, and he has not had any meetings. During a face-to-face interview conducted on 02/22/23 at approximately 12:45 PM, Employee#14 (Unit Manager 3 North) acknowledged the findings and made no comment.	F 657		

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F 657	Continued From page 86 3. Resident #60 was re-admitted to the facility on 02/11/22 with multiple diagnoses including Hemiplegia, Cerebral Infarction, and Morbid Obesity. A review of an IDT conference sign-in sheet revealed two conferences had been conducted.The first took place on 02/17/22, and the secondon 05/24/22. A review of the resident's medical record lacked documented evidence the IDT conducted care planning conferences were conducted after 05/24/22. A review of Resident #60's Minimum Data Set showed quarterly assessments had been conducted on 07/14/22 and 10/11/22 and an annual assessment had been conducted on 01/11/23. During a face-to-face interview on 03/10/23 at approximately 4:00 PM, Employee #27 stated thatthe IDT should have conducted quarterly care planning conferences. Cross reference 22B DCMR sect. 3211.1(a)	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensurethat residents receive treatment and care in accordance with professional standards of	F 684		

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F 684	Continued From page 87 practice, the comprehensive person-centeredcare plan, and the residents' choices. This REQUIREMENT is not met as evidencedby: Based on observations, record reviews and staff interviews, for six (6) of 104 sampled residents, the facility's staff failed to follow physician ordersor acceptable standards of practice evidenced byfailing to 1. provide Resident #56's daily mouth care, resulting in extensive oral thrush (yeast infection), 2. provide Resident #130's two-personassistance with incontinent care, 3. provide Resident #493's left-hand wound treatment, 4. provide intravenous fluids for Resident #313, 5. ensure straws were not provided to Resident #51as ordered, and 5. offload Resident #113's bilateral heals per physician's order. (Residents #56, #130, #493, #313, #51, and #113). Actual harm was present for Resident #56.The findings included: 1. Review of Resident #56's medical record showed that Resident #56 was admitted to the facility on 06/13/12 with diagnoses including: Tracheostomy, Chronic Respiratory Failure, Gastrostomy Status, Anoxic Encephalopathy, Traumatic Brain History and Persistent VegetativeState. Further review revealed a Quarterly Minimum Data Set (MDS) assessment dated 02/11/23 documented a Brief Interview for Mental Status (BIMS) summary score of "00", indicating that theResident had severely impaired cognition. In addition, the MDS assessment noted that the Resident was on enteral feeds, had a tracheostomy, had bilateral lower and upper	F 684	1.R130, R493, R313, R51 and R113 currently reside in the facility with no ill effects at this time. R130 had a skin assessment done by charge nurse on 3/1/23 with no issues noted, R493 was assessed by wound NP on 2/26/23, R313 assessed by charge nurse on 3/7/23, R51 assessed on 2/18/23 with no distress noted/verbalized, R113 assessed by charge nurse on 3/8/23 with no skin issues noted. R56 was assessed by the Medical Director on March 6, 2023. A new order was given for an oral antifungal for 5 days. The dentist assessed the resident’s oral cavity on March 9, 2023 and developeda treatment plan to meet the resident’s oral needs according to her disease process. Per the dentist, the RP was made aware of the treatment plan. Theresident’s yeast infection resolved. E23and E47 were educated on providing daily mouth care to residents. The straws were immediately removed from resident 51’s meal tray. The Registered Dietician validated that the resident has an order for “no straws” inthe medical record and on the meal ticket. E37 and E38 were educated on following plan of care based on physician orders related to no straws. R130’s incontinence care wascompleted upon observation on 2/24/23 and on-going. E31 was educated to provide incontinence care per the resident’s plan of care. R493’s wound was changed onFebruary 22, 2023. No signs or symptoms of infection were noted. R313’s IV fluids were placed on an IV pole upon awareness. The resident’s IV fluid	06/09/2023

order was completed on February 23, 2023. R113's heels were offloaded immediately upon awareness by the nursing staff.

2. The DON or designee will conduct interviews of residents and families on to ensure that oral care is provided per resident needs, no straws are provided when there is an order for no straws, that staff will provide toileting assistance with the required number of staff as ordered, that wound care treatments are completed per orders, that IV fluids are hung using an IV pole or per standards of care, and that resident's heels are offloaded per provider orders. All Residents on tube feeding have the potential to be affected. All Residents that have an order for no straws have the potential to be affected. All Residents on IV have the potential to be affected. All residents that required incontinent care has the potential to be affected. Findings showed that residents with "no straws" orders did not receive a straw, residents on IV had the IV bag hung on an IV pole, resident requiring incontinence care were assisted by the appropriate number of staff, residents on tube feeding received oral care as ordered.

3.The Nurse Educator or designee will in-service the nursing staff to ensure that oral care is provided per resident needs, that no straws are provided when there is a provider order for no straws, that staff will provide toileting assistance with the required number of staff as ordered, that wound care treatment(s) are completed per orders, that IV fluids are hung using an IV pole or per standards of care, and that resident's heels are offloaded per provider orders. The Dietary Director or designee will in-service the dietary staff that no straws are provided on meal trays when there is an order for no straws.

4.The DON or designee will audit 20% or the facility's census to ensure that that oral care is provided per resident needs, that no straws are provided when there is

an order for no straws, that staff will provide toileting assistance with the required number of staff as ordered, that wound care treatment(s) are completed per orders, that IV fluids are hung using an IV pole or per standards of care, that resident's heels are offloaded per provider orders. The Dietary Director or designee will audit random meal trays to ensure that no straws are provided when there is an order for no straws. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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F 684	Continued From page 88 extremity impairments on both sides, and was totally dependent on facility staff for all assisted daily living (ADL) care (bathing, oral hygiene, personal hygiene, bed mobility, and transfers). Review of a History and Physical Assessment dated 1/18/22 at 7:18 PM revealed: " ... Resident with non-communicating encephalopathic ...alert,but non-communicative. Patient with chronic tracheostomy ...at baseline ...no acute distress ..." Review of the following Physicians Orders dated 04/17/22 showed: "Assist with bathing, dressing, eating, mobility, and continence. Mouth care every shift. Suction as needed." Review of the Certified Nurse's Aide (CNA) Documentation Report for Resident #56 from February 1, 2023, to March 6, 2023, showed thatthe CNAs documented that they provided personal hygiene daily. Review of Resident #56's Treatment Administration Record (TAR) for February 1, 2023, to March 6, 2023, showed that the nurses documented that they provided mouth care everyshift. During a tour and observation of the 1 North Uniton 03/06/23 at 1:09 PM, Resident #56's representative asked to speak with a surveyor in the Resident's room. Upon entering the room, theResident's representative, and Employee #23 (1 South Unit Manager) were at the Resident's bedside. The surveyor observed Resident #56 lying in the bed positioned on his/her back. The Resident was wearing a gown from the facility and had a hand towel across the left shoulder and chest. The Resident's Representative was	F 684		

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F 684	Continued From page 89 very upset because the staff had not cleaned the Resident adequately or provided proper mouth care. The Representative said that due to sickness, she had not been able to come to visitthe Resident as frequently, so today, when she walked in, she noticed a thick coating on the Resident's tongue that looked like thrush. Thrush is a yeast infection seen in individuals with suppressed immune systems that can be causedby poor oral hygiene. (https://www.mayoclinic.org/diseases-conditions/o ral-thrush/symptoms-causes/syc-20353533 www.mayoclinic.com). In addition, the Representative stated that a bump on the Resident's top right gum looked likean abscess. The Representative then lifted the Resident's top lip to reveal a bump on the Resident's top right gum. The bump was pale pink and brown and was not bleeding. The surveyor also observed a thick white coating on the Resident's tongue. The Representative statedthat the white coating on the Resident's tongue and the bump on the Resident's gum were not there the last time she visited the Resident. The family member stated, "I am very frustrated and concerned ...[Resident #56] is totally dependent, and the staff does the bare minimum when I am not here. [Resident #56] already has a weakenedimmune system. If it were to spread, an infection in [pronoun] mouth could cause serious harm likesepsis " The family member then told the Unit Manager to contact only the Medical Director toassess the Resident's mouth. Review of a Nurse's Note on 03/06/23 at 2:24 PM documented: Oral thrush/Abscess: Resident's [representative] visits today complained ....that	F 684		

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F 684	Continued From page 90 Resident has oral thrush and abscess in the mouth. RP (representative) requested only [Medical Director] to do an oral assessment specifically to abscess and thrush ....new order for Diflucan 100 mg (milligrams) via G tube (gastrostomy tube) for 5 (five) days .... " During a face-to-face interview on 03/06/23 at 4:30 PM, Employee #10, (Medical Director) stated, "[Resident #56] did not have an abscess,but did have extensive thrush (yeast infection) throughout [pronoun] mouth." During a face-to-face interview on 03/06/23 at 5:16 PM, Employee #47 (Licensed Practical Nurse assigned to Resident #56) stated, "Mouth care did not occur. Today was fast-paced, and wewere short-staffed. The other nurse came late, and I was the only nurse on the unit. I know the Resident's mouth care is the nurse's responsibility." Review of a Nurse's Note on 03/06/23 5:27 PM documented: "MD Visit: Resident was seen at(the) bedside by [Physician's Name] stated there is no abscess " Facility staff documented that they provided mouth care to Resident #56 on the MAR and CNA report; however, the evidence (observationand staff interviews) showed that the Resident was not receiving mouth care every shift daily, per the physician's order. 2. Facility staff failed to ensure that per physician's order, no straws were provided to Resident #51, who had dysphasia and was at riskfor choking.	F 684		

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F 684	Continued From page 91 A Review of Resident #51's medical record revealed that the Resident was admitted to the facility on 07/15/2022 with diagnoses including: Dysphagia (difficulty swallowing), Neuroleptic Induced Parkinsonism, Cerebral Infarct, Seizures,and Dementia. Review of a physician's order dated 01/05/23 documented: "Regular diet, pureed texture, nectar thick consistency, No straws." Review of a Speech Language Pathology (SLP) Evaluation and Plan of Treatment dated 01/06/23 documented: "...Thin Liquids -Straw - ...Mild, clinical s/s (signs and symptoms) of dysphasia (difficulty swallowing); ...patient with silent aspiration (accidentally inhaling food, or thin liquidinto the trachea without knowing it) of thin liquids ...." A review of the Resident's medical record revealed a Quarterly Minimum Data Set (MDS)assessment dated 01/07/23 documented a BriefInterview for Mental Status (BIMS) summary score of "05", indicating that the Resident had severely impaired cognition. In addition, the Resident was noted as having a swallowing disorder (holding food in mouth/cheeks ...coughing or choking during meals), requiring a mechanically altered diet (e.g., pureed food, thickened liquid), and extensive assistance fromstaff when eating. Review of Resident #51's medical record showedthat in the "Documentation Survey Report" for February 2023, facility staff assisted the Residentwith setting up the meal tray and feeding the Resident.	F 684		

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During an initial tour observation on 02/17/23 at 12:45 PM, Resident #51 was observed lying on [pronoun] back in bed with the head of the bed raised. The Resident's uncovered lunch tray and two unwrapped drinking straws were placed on the bedside table directly in front of the Resident and within the Resident's reach. At 12:49 PM, Employee #36 (Certified Nurse Aide; CNA) entered the room. The surveyor asked if Resident# 51 was supposed to have straws on her tray.
The CNA looked at the sign above the Resident, removed the straws, and discarded them in the trash.

During an observation on 03/02/23 at 12:30 PM, Employee #37 (CNA) was observed at Resident #51's bedside. The Resident was in bed with the head of the bed raised. The Resident's bedside table was positioned across the Resident's bed, in front of the Resident. On top of the bedside table were the Resident's lunch tray, two unwrapped straws, and the Resident's meal ticket. The meal ticket did not indicate that the Resident was to have no straws. Employee #37 was feeding the Resident. When asked about thestraws on the Resident's lunch tray, the Employee stated, "We never use the straws when feeding or assisting the Resident with meals, andthe Employee removed the straws."

During a face-to-face interview on 03/02/23 at 12:39 PM, Employee #38 (1 North Unit Manager),when asked if facility staff check meal trays before handing them out to the Residents, responded," Yes, the CNAs and nurses check thetrays." The surveyor showed the Employee the physician's order which stated, "...No Straws." Employee #38 acknowledged that facility staff

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F 684	Continued From page 93 should have checked Resident #51's meal to ensure no straws were on the Resident's tray. Cross reference 22B DCMR sect. 3211.1(i) 3. The facility's staff failed to provide Resident #130 with two-person assistance during toiletingas ordered by the physician. Resident #130 was admitted to the facility on 11/04/20 with multiple diagnoses that included: Paraplegia, Morbid Obesity, Spondylosis of Lumbar region, Weakness, and Low Back Pain. Review of Resident 130's medical record revealed a Care Plan dated 11/04/20 that documented "Focus - [Resident's name] has anADL (Activities of Daily Living) self-care deficit needing assistance with ADL's r/t (related to) generalized weakness, lumbar stenosis, lower extremity numbness, morbid obesity, bilateral thigh swelling, functional paraplegia-likely multifactorial, spondylosis, epidural, lipomatosis, debilitation; Intervention/Tasks - Bed Mobility: [Resident's name] requires extensive assistanceby (2) staff to turn and reposition in bed ...ToiletUse: [Resident's name] requires extensive assistance by (2) staff for toileting." A physician's order dated 12/10/20 documented "2-staffs assist with ADL (Activities of Daily Living) every shift." A Quarterly Minimum Data Set (MDS) assessment dated 12/17/22 documented Resident #130 had a Brief Interview for MentalStatus summary score of "15" indicating the resident had an intact cognitive status and	F 684		

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Functional Status for Activities of Daily Living indicating 2-person physical assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene.

Review of the Treatment Administration Record dated 02/01/23 - 02/28/23 revealed documented evidence that facility staff signed off to completingassistance by two staff with ADL care each shift per physician order.

During a face-to-face interview with Resident #130 on 02/24/23 at 2:14 PM, the resident statedEmployee #31 entered the room to provide care because he/she had a bowel movement. The resident stated the certified nursing assistant (CNA) began cleaning her but she had to give instructions because she "still felt dirty and still feel the stool" on buttocks. The resident stated, "Igrabbed a wipe (disposable cleaning cloth) and reached back to clean myself, then showed the CNA the stool that was wiped from my buttocks."The resident stated she had some sensitive areas on her buttocks and asked the CNA to be gentle when wiping her. The resident then statedthe CNA was, "wiping me hard and didn't clean me well so I asked the CNA to stop and go get the Nurse." When the CNA didn't stop, the resident stated, "I grabbed her hand to make the CNA stop, told the CNA to stop touching me and go get the nurse," then the CNA left the room.

A telephone interview of Employee #31 on 03/09/23 at 08:48 AM revealed the employee worked the night shift (11:00 PM on 01/15/23 to 07:00 AM on 01/16/23) and was assigned to assist Resident #130 with ADL (activities of daily living) care. Employee #31 stated the morning of01/16/23 at approximately 2:00 AM, the resident

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F 684	Continued From page 95 called (pressed her call bell) because "she needed to be changed, I went to the room, she told me she don't need soap so I used water and a wipe, placed the wipe and wiped up then down,then I finished cleaning her front private area ... Then the resident said stop it go call the nurse. I said let me turn you back, I can't leave you or youwill fall ...I went to call the staff nurse ..." Employee #31 stated the resident told the staff nurse that "I refused to clean her ... I said Ma'am that didn't happen ..." Employee #31 stated whenthe nursing supervisor arrived, she asked "why didn't anybody tell you there were issues with theresident; have someone go to the resident's roomwith you; always send two people to the resident'sroom not just one person. I told her there were two other staff that wasn't allowed to go in her room and they didn't tell me." A telephone interview of Employee #32 on 03/10/23 at 10:04 AM, it was reported the CNAhad gone to work with Resident #130 alone. Employee #32 asked the CNA if orientation on how to wash the resident's perineal area and howto attend to the resident because Resident #130 is a 2-person assist, was provided and the CNA said no. Employee #32 stated the CNA was "substituted with other staff because the residentdidn't want [Employee #31] to take care of her anymore." Employee #32 further stated, "I sent 2other staff who went to clean the resident, requires 2 people because she a bariatric patientand has preference on who she wants to work with her; the resident is difficult to work with whenthe person is new to her, she likes regular staff." Employee #32 further added "normally, the Nursefor the team would have oriented the CNAs on the resident's preference, the resident has an order that for 2-person assist." Employee #32	F 684		

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F 684	Continued From page 96	F 684		

was asked if Resident #130 had mentioned being abused, and [pronoun] stated "No, she never mentioned being abused, she said that the CNA didn't clean her well because she felt like she wasstill dirty."

During a face-to-face interview with Employee #3on 03/10/23 at 04:51 PM, the employee acknowledged Resident #130's Physician Order,Treatment Administration Record and Care Plan for 2-person assist for ADL's (Activities of Daily Living).

4. The facility's staff failed to provide Resident #493 wound care to the left-hand as ordered bythe physician.

Resident #493 was admitted to the facility on 02/15/23 with multiple diagnoses including Bullous Disorder, Anemia, and Protein-Calorie Malnutrition.

A review of the resident's medical record revealedtwo physician treatment orders for the resident's left-hand dated 02/17/23. The first order instructed, "Left dorsal hand with multiple bullae scars: Cleanse with NSS (normal saline) and pat dry. Apply Aquaphor, cover with abd (abdominal)pad and wrap with kerlix, secure with kerlix, secure with tape Q [every] MWF [Monday, Wednesday, Friday] for wound care. And the second order documented, "Left palm with improving bulla: Cleanse with NSS, pat dry. Applyskin prep, then cover with abd pad and wrap withKerli, secure with tape Q MWF every day shift every MWF."

The treatment administration record (TAR)

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F 684	Continued From page 97 revealed a nurse's initials indicating that woundcare was provided for the resident on Monday,02/20/23. A review of the resident's Treatment Administration Record (TAR) showed the following day shift orders: -"Left dorsal hand with multiple bullae scars: Cleanse with NSS (normal saline) and pat dry. Apply Aquaphor, cover with abd (abdominal) padand wrap with kerlix, secure with kerlix, secure with tape Q [every] MWF [Monday, Wednesday,Friday] for wound care. -"Left palm with improving bulla: Cleanse with NSS, pat dry. Apply skin prep, then cover with abd pad and wrap with Kerli, secure with tape QMWF every day shift every MWF." An observation was made at approximately 1:25PM on 02/21/23 (Tuesday), showing the residentsitting in bed, gazing out the window. On the resident's left hand was a white dressing with a small yellowish stain. In addition, written on the dressing was the date 02/18/23. Employee #27 (ADON) stated on 02/21/23 at approximately 3:00 PM that wound care was not provided to Resident #493 on Monday 02/20/23. A review of an admission Minimum Data Set assessment dated 02/22/23 revealed that Resident #493 received a Brief Interview for Mental Status summary score of "1", which indicates severe cognitive impairment. In addition, the resident was coded as having openlesions.	F 684		

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F 684	Continued From page 98 5. The facility's staff failed to follow accepted Standards of Practice when hanging intravenousfluids for Resident #313. Resident #313 was admitted to the facility on 11/11/22 with multiple diagnoses including Dementia and Dysphagia. A review of a physician order dated 02/10/23, instructed, "D (Dextrose) 5 ½ NS (normal saline)at 75 cc (cubic centimeters) X 3L (Liters) ..." A review of the a physician order dated 02/13/23, instructed, "D (Dextrose) 5 ½ NS (normal saline)at 75 cc (cubic centimeters) X 3L (Liters) ..." During multiple observations from 02/13/23 to 02/16/23 11:00 AM, to 3:00 PM, Resident #313 was observed lying in bed receiving IV fluids via aleft upper arm IV site. The resident's fluids were hanging from an IV pole at the head of the resident's bed. A review of Resident #313's February 2023 Medication Administration Record revealed the resident received IV fluids as ordered. A review of a Significant Change Minimum data Set dated 02/18/23 documented, the resident hadshort term and long term memory problems and severely impaired with cognitive skills for daily decision making. In addition, the resident was coded for receiving intravenous feeding. A review of a State Agency Compliant Intake Form (DC00011687) dated 02/22/23 at 4:28 PM documented, " ...The IV bag was hung on a hanger because there was not an IV (intravenous) pole available ..."	F 684		

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F 684	Continued From page 99 A review of a photo provided by the complainant ,noted Resident #313 was lying in bed with the head of the bed elevated at a 90-degree angle. Lying on the top of the resident's bed was a 1000cc bag of IVF (intravenous fluids). Attachedto the fluids was an IV line that was connected tothe resident's left upper arm IV site. An observation of the central supply equipment storage area on 03/06/23 at approximately 10:00AM, showed the facility had one assembled iv pole and multiple boxes of unassembled IV poles.At the time of the observation, Employee #61 (Central Supply Director), stated that there is a central supply staff person available in the evening to provide equipment. The employee also said nursing supervisors have access to thecentral supply equipment storage area during afterhours. During a telephone interview on 03/06/23 startingat 11:51 AM, the complainant stated that the facility did not have an IV pole for hours to hang the resident's IV. The complainant also said that the family started taking pictures to show how thefacility placed Resident #313's IV on the bed. During a face-to-face interview on 03/06/23 starting at approximately 4:00 PM, Employee #3(DON) reviewed the complainant's picture and stated that was not the standard of practice to place IV fluids on the resident's bed. The employee also stated the Standard of Practice isthat staff use an IV pole when hanging IV. Cross reference 22B DCMR sect. 3211.1(a) 6. The facility's staff failed to follow Resident #113's physician's order to offload [pro-noun]	F 684		

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F 684	Continued From page 100 bilateral heels. Resident #113 was admitted to the facility on 06/09/17, with multiple diagnoses that included the following: Encephalopathy, Gastrostomy Status, and Contracture of Muscle Multiple Sites. During a resident observation conducted on 03/03/23 at approximately 11:45 AM, Resident #113 was observed laying on an air mattress withthe head of the bed raised approximately 45 degrees. Resident #113's heels were observed on the mattress, and they were not offloaded. A review of the medical record revealed the following: [Physician Order] 08/10/22 "Offload bilateralheels every shift" A review of the Quarterly Minimum Data Set (MDS) dated 12/16/22 showed that the facility staff coded that the resident was unable to complete a "Brief Interview for Mental Status" andthat the resident has no speech and is rarely/never understood and rarely/never understands others. The facility staff coded that the resident needs extensive assistance and requires 2 persons to assist with bed mobility transfers and dressing. The facility staff coded the resident as having impairment on both sides in the upper and lower extremities, and the resident is at risk for developing pressure ulcers/injuries. A review of the "Treatment Administrative Record" (TAR) dated 03/03/23, in the section titled "Offload bilateral heels every shift" shows that staff documented a check mark for the day shift	F 684		

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F 684	Continued From page 101 indicating the task was completed. During a face-to-face interview conducted on 03/03/23 at approximately 12:00 PM, Employee#18 (Unit Manager 3 South) acknowledged thefindings and stated, "It was left out by the CNA(certified nurse aide)."	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure UlcerCFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressureulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and preventnew ulcers from developing. This REQUIREMENT is not met as evidencedby: Based on observation, record review and staff interview for one (1) of 105 sampled residents (231), facility staff failed to follow physician's orders to provide weekly skin assessments for a resident who is bedridden and totally dependentof care as evidenced by a pressure ulcer to the sacrum that facility staff first discovered and documented at an unstageable level. The findings included: Resident #231 was admitted to the facility on	F 686		

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F 686	Continued From page 102 12/24/21 with multiple diagnoses that included: Vascular Dementia, Cognitive Communication Deficit, Muscle Weakness, End Stage Renal Disease, Malignant Neoplasm of Lung, Heart Failure, Cerebral Infarction, Dysphagia and Type2 Diabetes. Review of Resident #231's medical record revealed a Care Plan dated 12/24/21 that documented "Focus - [Resident's name] has actual impairment to skin integrity r/t multiple wounds ... Interventions/Tasks - Monitor/document location, size and treatment ofskin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD ...Turn and reposition every 2 hours and PRN (as needed)." A Braden Scale dated 12/24/21 revealed a Braden Score of "11" indicating the Resident wasa High Risk for skin impairment. An Admission/Readmission Screener dated 12/24/21 revealed "Skin Integrity: Color-Normal, Temperature-Warm/Dry, Turgor-Normal, Location-sacral pressure." A Care Plan dated 12/24/21 documented: -"Focus - [Resident's name] has limited physical mobility, Goal - [Resident's name] will remain freeof complications related to immobility, including ... skin-breakdown through the next review date in90 days, Interventions/Tasks - Monitor/document/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of immobility: contractures forming or worsening, skin-breakdown ..." -"Focus - [Resident's name] has an ADL	F 686	1. R231 was discharged from the facility on 04/25/2023. E27 waseducated on following physician orders for weekly skin assessment. 2. The Wound nurse manager or designee will review current residents who are totally dependent of care. The wound nurse will ensure weekly skin checks are completed per physician order. Findings indicated that there were 5 residents who did not have a weekly skin check. A skin check was initiated for those residents. All residents who are dependent for care have the potential to be affected. 3. The Nurse educator or designee will in-service the licensed professional nurses to ensure weekly skin checks are being done per physician order. 4. The Wound nurse manager or designee will audit 20% of residents who are totally dependent of care to ensure weekly skin checks are being done per physician order. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	06/09/2023

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F 686	Continued From page 103 (Activities of Daily Living) self-care deficit needing assistance with ADL's r/t (related to) history of stroke, seizures, vascular dementia, AMS (alteredmental status) ...Intervention/Tasks - Skin Inspection: [Resident's name] requires SKIN inspection as ordered. Observe for redness, openareas, scratches, cuts, bruises and report changes to the Nurse." Review of Resident #231's medical record revealed the following: -physician's orders dated 01/12/22 at 2345 (11:45PM) that documented "weekly skin checks by licensed nurse and notify MD/NP (medical doctor/nurse practitioner) of any abnormality every evening shift every Mon (Monday)." -an SBAR (Situation, Background, Assessment/Appearance, Request) - Physician/NP (nurse practitioner)/PA (physician assistant) Communication Tool dated 11/22/22 at13:00 (1:00 PM) that documented "1. Describe the problem/symptom: Resident was noted with reopen wound on coccyx; 2. Date problem or symptom started: 11/22/2022; 3. Identify whetherthe problem/symptom has gotten worse/better/stayed the same since it started: Worse." -a Nurses Progress Note dated 11/22/2022 at 13:55 (1:55 PM), that documented "Resident wasnoted with re-open wound on coccyx during am (morning) care. Resident is non-verbal. Wound team was call, came and assess wound, NP (nurse practitioner) was call, order given to cleanse wound with normal saline, pat dry and apply silver alginate, and cover with 4x4. RP (responsible party) was call and updated."	F 686		

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F 686	Continued From page 104 -a Care Plan dated 11/22/22 that documented "Focus - [Resident's name] was noted sacrum wound on 11/22/22 ...Goal - will be free from complication related to healing through next review date x 90 days ...Intervention/Tasks - Treatment as ordered, wound consult, continuewith at risk skin care plan interventions." An Order Summary Report in the resident'srecord dated: -11/23/22: "Cleanse wound with NS - pat dry, apply silver alginate and cover with 4x4 gauze until healed two times a day for wound healing;" -11/23/22: "Clean with normal saline, pat dry apply silver alginate and cover with dry dressingevery day shift for wound care. Start Date 11/24/2022," indicating no site was specified onthe previous Order Summary Report. Review of Resident #231's medical record, revealed a document titled Tissue Analytics (wound evaluation) dated 11/30/2022 at 09:38 AMthat documented, "Measurements-Length: 5.14 cm (centimeter) (+4.8) Width: 6.36 cm (+52.5); Date Wound Acquired: 11/22/22; % granulation: 60.00, % slough/eschar: 40.00, Depth (cm): 0.10;Wound Status: New; Acquired in House?: Yes; Etiology: Pressure Ulcer - Unstageable; PressureReduction/Offloading: Ensure compliance with turning protocol, Wedge/foam cushion for offloading, Wheelchair Cushion, Specialty Bed; Dressings: Hydrogel; Secondary Dressing: Bordered foam; PUSH [Pressure Ulcer Scale for Healing-ranges from 0 (healed) to 17 (most severe wound)] score "14" " indicating the Resident had a deteriorating wound. Additional review of Resident #231's medical	F 686		

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F 686	Continued From page 105 record revealed a 12/14/22 Discharge Summary from a local hospital that noted the Resident wasdischarged from the dialysis facility on 12/02/22 and was brought sent to the local ED (emergencydepartment) due to "syncopal episode which occurred during dialysis. At admission, patient found to have elevated WBC (white blood count),right pleural effusion on CXR (chest x-ray), sacralulcer wound stage III, and right heel ulcer ...Patient is s/p (status post) sacral wound debridement on 12/5/22 and wound cultures grewproteus (susceptible to meropenem) and e. faecalis (susceptible to vancomycin). Patient wastreated with IV (intravenous) Meropenem 0.5g (grams) daily and Vancomycin dosed with dialysis - start date 12/2/22. Patient was seen by woundcare during her hospital stay." Review of Resident #231's medical record revealed an Order Summary Report dated 12/30/22 that documented "Skin Assessment on admission, on first bath/shower day of the week &PRN (as needed) one time a day every Tue (Tuesday), Start Date 01/03/2023." On 02/22/23 at 04:54 PM during a face to face interview, the RP (responsible party) of Resident #231, stated, "developed a pressure ulcer while at the facility a couple months ago on her buttocks, lower back and heels, [pronoun] been lying on her back for about a month so I've askedif they've been turning her often." During a face-to-face interview on 03/10/23 at 9:00 AM Employee #27, stated "No one told me about the sacrum ..." Employee #27 was asked ifthe staff were doing regular skin assessments and responded, "We were doing skin checks, butit's been a while since they were done, for some	F 686		

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F 686	Continued From page 106 months now. The charge nurse is supposed to doskin sweeps (checks) during showers, but not sure if being done." During a face-to-face interview on 03/10/23 at 11:32 AM Employee #3, was told that the ADONwas not aware of the new sacral wound for the Resident on the unit and the employee stated "[ADON] might not have been here for the IDT (Interdisciplinary Team) Meeting that's why they probably weren't aware. Employee #3 was askedif they have access to wound care reports and responded, "We see the same thing in the recordthat you see, we get the report from [wound carestaff] and make recommendations from there. We spoke with them because it seems as thoughshe had a DTI (deep tissue injury), but opened upto a Stage 3, but I acknowledge that there was nodocumentation of assessments being done starting at a DTI before it progressed to that pointof Unstageable pressure ulcer." Follow-up interview with Employee #27 to clarify treatment orders when the new sacrum pressureulcer was first noted. Employee #27 stated, "It didn't have the site for the first order then it was corrected to add the site at the Sacrum from thetime we first saw it, this is the date of the order [11/23/2022]."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remainsas free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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F 689	Continued From page 107 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidencedby: Based on observations, record reviews, residentand staff interviews for one (1) of 105 sampled residents, the facility's staff failed to ensure that Resident #51's environment was free of accidenthazards by 1. not removing drinking straws from the resident's meal tray, 2. having two portable space heaters in the clean linen area of the facility, and several cracks from the concrete driveway and sidewalk, located at the entrance ofthe facility, that presented a tripping hazard. The findings included: 1. Review of Resident #51's medical record revealed that the Resident was admitted to the facility on 07/15/2022 with diagnoses including: Dysphagia (difficulty swallowing), Neuroleptic Induced Parkinsonism, Cerebral Infarct, Seizures,and Dementia. Review of a physician's order dated 01/05/23 documented," Regular diet, pureed texture, nectar thick consistency, No straws." Review of a Speech Language Pathology (SLP) Evaluation and Plan of Treatment dated 01/06/23 documented: "...Thin Liquids -Straw - ...Mild, clinical s/s (signs and symptoms) of dysphagia (difficulty swallowing); ...patient with silent aspiration (accidentally inhaling food, or thin liquidinto the trachea without knowing it) of thin liquids ...." Review of the Resident's medical record revealeda Quarterly Minimum Data Set (MDS)	F 689	1.R51 currently resides in thefacility with no ill effects. Resident was assessed on February 25, 2023, by the physician. Straws were immediately removed from R51 meal tray upon awareness by the nursing staff. The Registered Dietician validated that the resident has an order for “no straws” in the medical record and on the meal ticket. The portable space heaters in the cleanlinen area of laundry services were removed immediately upon observation. The cracks from the concrete driveway and sidewalk, located at the entrance of the facility were repaired prior to the survey exit. 2.The Dietary director or designee will review meal tickets for current residents who have “no straw” orders to ensure that straws are not placed on their tray. Findings indicated that no straws were served to residents with a “no straw” order. The unit manager or designee will review current resident in the facility who have “no straw” orders to ensure that straws are not placed on their tray. Findings showed that no resident was provided with a straw who had a “no straw” order. The Environmental service director or designee will review the clean linen area of laundry services to ensure that there are noportable space heaters present. Findings indicated that no additional space heaters were found. The Maintenance director or designee will review the concrete driveway and sidewalksto ensure there are no tripping hazards present. Findings showed that no additional tripping	06/09/2023

hazards were found in the identified areas.
All residents have the potential to be effected.

3.The Nurse educator or designee will in service the dietary and nursing staff to ensure that residents with "no straw" orders have no straws placed on their meal tray.

The Environmental service director or designee will in service the environmental service staff to ensure that there are no portable space heaters present in the clean linen area of laundry.

The maintenance director or designee will in service the maintenance staff to ensure that the concrete driveway and sidewalks are free of tripping hazards, including but not limited to cracks in the concrete.

4.The Director of dietary or designee will audit random meal tickets to ensure that residents who have a "no straw" order do not have straws placed on their meal tray. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.

The Unit manager or designee will audit random meal trays to ensure that residents who have a "no straw" order do not have straws placed on their meal tray. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.

The Director of environmental services or designee will audit clean linen area of laundry to ensure that there are no portable space heaters present. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

The Director of Maintenance or designee will ensure that the concrete driveway and sidewalks are free of tripping hazards, including but not limited to cracks in the concrete. Audits will be

conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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F 689	Continued From page 108 assessment dated 01/07/23 documenting a Brief Interview for Mental Status (BIMS) summary score of "05", indicating that the Resident had severely impaired cognition. In addition, the Resident was noted as having a swallowing disorder (holding food in mouth/cheeks ...coughing or choking during meals), requiring a mechanically altered diet (e.g., pureed food, thickened liquid), and extensive assistance fromstaff when eating. During an initial tour observation on 02/17/23 at 12:45 PM, Resident #51 was observed lying on [pronoun] back in bed with the head of the bed raised. The Resident's uncovered lunch tray and two unwrapped drinking straws were placed on the bedside table directly in front of the Resident and within the Resident's reach. Above the Resident's bed were two signs; one that read: "Nostraws, please feed/give pt (patient) sips from thecup," and another sign that read, "Patient is on a puree and nectar thick liquid upright position w (with/ intake, good oral care no thin liquids or ice cream." At 12:49 PM, Employee #36 (Certified Nurse's Aide; CNA), entered the room. The surveyor asked if Resident #51 was supposed to have straws on her tray, the CNA looked at the sign above the Resident's bed, removed the straws and discarded them in the trash. The Employee then stated that Resident #51 was safebecause we (facility staff) always assist [pronoun]with meals. Review of Resident #51's medical record showedthat on the "Documentation Survey Report" for February 2023, facility staff assisted the Residentwith setting up the meal tray and feeding the Resident.	F 689		

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F 689	Continued From page 109 During an observation on 03/02/23 at 12:30 PM, Employee #37 (CNA) was observed at Resident#51's bedside. The Resident was in bed with thehead of the bed raised. The Resident's bedside table was positioned across the Resident's bed,in front of the Resident. On top of the bedside table was the Resident's lunch tray, two unwrapped straws, and the Resident's meal ticket. The meal ticket did not indicate that the Resident was to have no straws. Employee #37 was feeding the Resident. When asked about the straws on the Resident's lunch tray, the Employee reported that staff never use the straws when feeding or assisting the Residentwith meals, and the Employee removed the straws. During a face-to-face interview on 03/02/23 at 12:39 PM with Employee #38 (1 North Unit Manager), was asked what type of assistance theResident required with meals, and stated: "The Resident can feed herself a little. She wants to beas independent as possible, so first, we let the Resident feed herself. If we see that the tray has been sitting there for a while and the Resident hasn't eaten much, then we assist her. When asked if facility staff check meal trays before handing them out to the Residents, Employee #38 responded," Yes, the CNAs and nurses check the trays." In response to Resident #51 having straws on her meal tray, the Employee stated that the CNAs who assisted the Resident know not to use the straws. The surveyor pointedout that the Resident is sometimes left unsupervised with the straws on the meal tray. The Employee replied that the Resident was safe because the Resident could not open the drinkingstraws without assistance. The surveyor also	F 689		

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F 689	Continued From page 110 pointed out that the Resident had an order for "No Straws." Employee #38 acknowledged that facilitystaff should have checked Resident #51's meal tray more carefully and removed the straws. 2. Observations made on February 21, 2023, and February 22, 2023, at approximately 9:30AM, of the following: -Two (2) of two (2) portable space heaters wereseen in the clean linen area of laundry services.The heaters were not in operation at the time ofthe observation. -Numerous cracks were noted in the concrete driveway and sidewalks, at the front of the facility,that presented a tripping hazard to residents. These findings were acknowledged by Employee#6 on February 22, 2023, at approximately 11:00AM.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy andpercutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		

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F 692	Continued From page 111 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet whenthere is a nutritional problem and the health careprovider orders a therapeutic diet. This REQUIREMENT is not met as evidencedby: Based on observation, record reviews, family interview and staff interviews, for one (2) of 104 sampled residents, the facility's staff failed to adequately monitor a resident's nutritional statusand obtain after admission and at least monthly thereafter to help identify and document potentialweight loss or weight gain. (Residents #313 and#60) The findings included: A review of the policy titled, Weight Monitoring dated 02/01/22, instructed, "A weight monitoring schedule will be developed upon admission for all residents: weights should be recorded at the timeof obtained ... newly admitted residents -monitored weekly for 4 weeks. Resident with weight loss- monitor weight weekly ... All others-monitor weight monthly ...A significant change inweight is defined as 5% in weight in 1 month (30days) ..." Resident #313 was admitted on 11/11/22 with multiple diagnoses including Dysphagia, Lewy Body Dementia, Parkinson Disease, and Stage 4Sacral Pressure Ulcer.	F 692	1. R313 and R60 both reside in the facility with no ill effects currently. The weight for R313 was obtained on 3/7/23. The weight for R60 was obtained on 3/3/23. R51 was assessed on 3/3/23 by the nurse practitioner and R60 was assessed on 3/4/23 by the nurse practitioner. E28 and E11 educated on assuring that weights are monitored for admissions weekly and for residents with significant weight change and if resident refuses weights that it should be documented. E57 was educated on addressing reason for weight variancesand documenting interventions in place. 2. The Dietician or designee will review admissions/readmission weights to ensurethat weights are obtained according to the facility's weight policy; residents who havea significant weight variance interventionwill be implemented and documented. All residents have the potential to be affected. Findings indicated that 2 residents had significant weight loss and appropriate interventions were implemented. 3. The Nurse educator or designee will in service the nursing staff and dieticians to ensure that admission/readmission weightsare obtained according to the facility's weight policy and any refusals will be documented; residents who have a significant weight variance intervention will be implemented and documented. 4. The Quality assurance or designee will review admission/readmission weights to assure that weights are obtained according to the facility's weight policy and any refusals are	06/09/2023

documented and residents whohave a significant weight variance intervention are documented. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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F 692	Continued From page 112 A review of a care plan with an initial date of 11/11/22 documented, "Focus - [Resident's name]has an ADL (activity of daily living) self-care deficitneed assistance with ADLs r/t (related to) Altered Mental Status, Dementia Associated with Parkinson's disease ...Intervention - Eating: [Resident's name] is totally dependent on (1) stafffor eating. A review of a physician order dated 11/12/22 instructed, "Regular diet, pureed texture, thin consistency." A review of a document titled, "Weights and Vitals Summary," documented the resident's weight on 11/12/22 as 105 pounds. A review of an Admission Minimum Data Set dated 11/18/22 documented, under the CognitiveSkills for Daily Decision-Making section, the resident was coded as "3" indicating that the resident was severely impaired (never/rarely made decisions). A review of a physician order dated 12/06/22 instructed, "Regular diet, mechanical soft, thin consistency." A review of a care plan dated 12/14/22 documented: "Focus Area- [resident's name] needs mechanically altered diet r/t [related to] dysphagia, increased to caloric needs r/t (related)suboptimal intake, [and] wound healing. Intervention ...monitor wts (weights) ..." A review of a document titled, "Weights and Vitals Summary," documented the resident's weight on 12/21/22 as 99.5 pounds.	F 692		

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F 692	Continued From page 113 A review of a document titled, "Weights and Vital Summary" revealed that the facility's lacked documented evidence that the facility's staff weighed the resident for 3 weeks after admissionfrom 11/12/22 to 12/03/22. A review of progress notes, medication administration records, and treatment administration records lacked documented evidence that the facility's staff weighed Resident#313 for three (3) weeks from 11/13/22 to 12/03/22. In addition, the record lacked documented evidence that the resident refused tobe weighed during that time frame. A review of progress notes, medication administration records, and treatment administration records lacked documented evidence that the facility's staff weighed Resident#313 from 11/12/22 to 12/21/22. In addition, the record lacked documented evidence that the resident refused to be weighed during that time frame. A review of a document titled, "Weights and Vital Summary" lacked documented evidence that the facility's staff weighed the resident in January 2023 and February 2023. A review of a physician order dated 02/03/23 instructed, "Regular diet, pureed diet, thin consistency." A review of progress notes, medication administration records, and treatment administration records lacked documented evidence that the facility's staff weighed Resident#313 for three (3) weeks from 01/01/23 to 02/28/23. In addition, the record lacked	F 692		

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F 692	Continued From page 114 documented evidence that the resident refused tobe weighed during that time frame. Multiple observations were conducted between 02/13/23 and 03/03/23, from approximately 8:30AM to 4:00 PM, and showed Resident #313 lyingin bed with eyes open, but not responding to verbal stimuli. In addition, the family was observed feeding home-cooked meals to the resident on two occasions. During a face-to-face interview on 03/03/23 at approximately 4:00 PM, Employee #28 (Unit Manager/RN) stated that the facility's policy is to weigh newly admitted residents weekly for 4 weeks after admission. The employee said after the staff weighed the resident, she documents theresident's weight in the resident's medical record.When asked, was there a reason why the resident did not have weights for three weeks from 11/12/22 to 12/03/22, Employee #28 said that perhaps the resident refused but she could not explain why. When asked, how could the resident refuse when the resident appears to be confused (to name, time, and place), the employee failed to provide an answer. In addition, she could not explain why the resident did not have weights for January 2023 and February 2023. It should be noted after the interview, the surveyor was provided a revised care plan dated 03/03/23 for Resident #313's that documented, "Focus Area- [Resident's name] has a behavior problem r/t (related to) refusal of monthly weights.Goal- [resident's name] will have fewer episodes of refusal of monthly [weights]. Intervention - monitor behavior episodes and attempt to determine underline cause ..."	F 692		

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F 692	Continued From page 115 During a face-to-face interview on 03/06/23 at 10:14 AM, Employee #11 (Dietician) stated thatthe resident should have been weighted weeklyafter the significant weight loss 5.2 percent on 12/21/22. 2. Resident #60 was admitted to the facility on 02/11/22 with multiple diagnoses including Dysphagia, Gastrostomy Status, and Hemiplegia. Review of a document titled "Weights and Vitals Summary" documented the resident's weight was269 pounds on 02/11/22. A review of a physician order dated 02/11/22, instructed, "NPO diet..." A review of an admission nursing note date 02/11/22 at 10:57 PM, documented, " ...Residentis NPO (nothing by mouth) with G Tube (gastrostomy tube) for nutrition. Started Jevity 1.5, 1 can Q (every) 4 hours ..." A review of a physician order dated 02/11/22 instructed, "Thiamine HCI 100 MG - give 1 tabletvia G-tube one time a day for supplement." A review of a physician order dated 02/12/22, instructed, "Jevity 1.5 1 can Q 4 hours via G-tubefor enteral feeding." A review of a physician order dated 02/14/22, instructed, "Pleasure feeding diet. Pureed texture ..." A review of a physician order dated 02/16/22 instructed, "Enteral Feeding Order' one time a	F 692		

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day continuous Jevity 1.5 at 75ml/hr (ml/hr) X 18 hrs=1350 ml (2025 calorie = 18 gm protein)."

A review of a nutrition assessment dated 02/16/22 at 11:26 AM documented, "Tube feeding ...Jevity 1.5 at 75ml/hr (ml/hr) X 18 hrs=1350 ml,2025 kcal (calorie), 86 gmpro (grams of protein) ...Resident new admit ... with dx (diagnosis) Dysphagia ...slp (speech) screen rec (recommended) start puree pleasure feeding. Wt.(weight) 269 lbs (pounds), stable above norm forbmi (body mass index), however closer to usual wt ..."

A review of a care plan dated 02/16/22 documented, "Focus area- [Resident #60] requires tube feeding r/t (related to) Dysphagianeeded to meet nutrition and hydration needs daily ...Goal [Resident #60] will maintain adequate nutritional and hydration status
...Intervention ...provide pleasure foods, resident dependent with tube feeding and water flushes ...RD (registered dietician) to evaluate ...PRN (as needed). Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed ..."

A review of Resident #60's Admission Minimum Data Set (MDS) dated 02/18/22 revealed the resident was coded as having short-term and long-term memory problems and being severely impaired with daily decision-making. The MDS documented the resident's weight as 269 pounds,height 6 feet 4 inch, receiving tube feeding, and receiving 51% or more calories from tube feeding.

A review of a nurses note dated 02/23/22 at 1:41PM, documented, "Resident peg tube

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F 692	Continued From page 117 [percutaneous endoscopic gastrostomy tube] wasout lying on bed beside him when I walked in his room around 8:00 AM. He is stable. No apparentdistress ... NP (nurse practitioner) was on the floor and assess resident with order to transfer toER for Peg tube replacement ..." A review of a nurses note dated 02/28/22 at 10:40PM, documented, " ...re-admission to the facility ...receiving feeding Jevity 1.5 [at]40 ml/hr X 18 hours via [pro-noun] PEG tube. At this time he isin stable condition ..." A review of a physician order dated 02/28/22 instructed, "Enteral Feeding Order" one time a day continuous Jevity 1.5 at 75ml/hr (ml/hr) X 18hrs=1350 ml (2025 calorie = 18 gm protein). Thiamine HCI 100 MG - give 1 tablet via G-tubeone time a day for supplement." A review of a nurse practitioner note dated 02/28/22 at 9:06 PM documented, "Pt. (patient) readmitted from [hospital name], where he was transferred for PEG dislodgement. PEG was replaced. Hospital course uncomplicated ...well nourished, alert and oriented X1 (to name) ...abd[abdomen] soft, NT (non-tender), ND (non-distended), +bs X 4 (positive bowel soundsin all four quadrants), PEG site dry and clean.." A review of Medication Administration Records from 02/12/22 to 03/07/22 revealed the residentwas administered tube feeding as ordered. Review of a document titled "Weights and Vitals Summary" revealed a weight of 229 pounds on 03/07/22, which was a significant weight loss of 14.87 percent (40 pounds) since 02/11/22 (twenty-eight days).	F 692		

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F 692	Continued From page 118 Resident #60's medical record lacked documented evidence that the facility's staff implemented interventions to address the resident's 40-pound weight variance from 02/11/22 to 03/07/22. In addition, the "Weightsand Vitals Summary" also noted Resident #60was not weighed in April 2022. A review of State Agency complaint intake form #DC00011471 dated 01/09/23 at 1:18 PM documented, " ...The nursing staff is not feeding [Resident #60] properly ...There is a significant difference in his current BMI in comparison to when he was initially placed at the facility ..." An observation on 02/13/23 at approximately 10:00 AM Resident #60 was observed lying in bed with an empty breakfast tray in the bedsidetable. When asked if he enjoyed breakfast, theresident shook his head indicating "yes". The resident appeared to be non-verbal. An observation on 02/17/23 at approximately 1:30PM, noted the resident was observed lying in bedwith an empty lunch tray on the bedside table. An observation on 02/21/23 at approximately 6:00PM, noted the resident was observed eating dinner. According to Resident #60's "Weights and Vitals Summary" between 05/02/22 and 03/03/23, his weight ranged between 220 pounds and 229 pounds. During a face-to-face interview on 03/08/23 at4:22 PM, Employee #57 (Dietician) was askedhow she addressed variance in the resident's	F 692		

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F 692	Continued From page 119 weight as recorded on the Weight and Vitals sheet. The employee stated that she believed theadmission weight was incorrect. She informed theunit manager, so the unit manager could inform the physician. Also, Employee #57 reported that the resident no longer received tube feedings andwas eating double portions of a regular texture diet. Additionally, his BMI was in the normal range. During a face-to-face interview on 03/10/23 at approximately 4:00 PM, the resident's physician (medical director) stated that the facility informedhim about Resident #60's 40-pound weight loss from 02/11/22 to 03/07/22. The physician statedhe believed the resident's weight was inaccuratebecause the nurse practitioner had seen him several times during that period, and he had notdisplayed any other symptoms of weight loss. Cross reference 22B DCMR sect. 3211.1(a)	F 692		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first90 days after admission, and at least once every60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after thedate the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physicianvisits must be made by the physician personally.	F 712		

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F 712	Continued From page 120 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physicianand visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidencedby: Based on review of medical record and staff interview, for one (1) of 102 sampled residents, the facility's staff failed to ensure Resident #313 was seen by a physician or nurse practitioner at least once every 30 days for the first 90 days afteradmission. The findings included: Resident #313 was admitted to the facility on 11/11/22 with multiple diagnoses including: Dementia, Stage 4 Sacral Pressure Ulcer, Hypertension, Muscle Weakness, and Bradycardia. A review of an Admission Minimum Data Set dated 11/18/22 documented the resident had anentry [admission] date of 11/11/22. A review of Resident #313's physician progress notes, nurse practitioner progress notes, and history and physical dated from 11/11/22 to 01/31/23 revealed there was no documented evidence that a physician or nurse practitioner saw the resident in December of 2022. During a face-to-face interview on 03/06/23 at approximately 12:45 PM, Employee #39 (Nurse Practitioner) stated that Resident #313's was assigned to her caseload. The employee explained that the resident should have been	F 712	1. R313 currently resides in the facility with no ill effects noted. E39 was educated that admissions/readmissions should be seenonce every 30 days for the first 90 days after admission. 2.The Medical records director or designee will review the past 30 days of admission/readmission to the facility to ensure that a medical provider has seen theresident at least once every 30 days after admission in the first 90 days post admission. Findings showed one resident not seen by provider since he was admitted on 5/17/23. All residents who are admissions/readmissions have the potential to be affected. 3.The Educator or designee will in service the medical director and physicians to ensure that residents who are admitted/readmitted to the facility are seen by a medical provider at least once every 30 days for the first 90 days after admission. 4.The Medical records director or designee will audit residents who are admissioned/readmissioned to ensure that residents are seen by a medical provider at least once every 30 days for the first 90 days after admission. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.	6/9/2023

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F 712	Continued From page 121 seen by a physician or nurse practitioner in December 2022 but the assessment was not conducted due to an oversight. Cross reference 22B DCMR sect. 3207.10	F 712		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each residentmust be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a reviewof the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale inthe resident's medical record.	F 756		

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F 756	Continued From page 122 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthlydrug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must takewhen he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidencedby: Based on record review and staff interview for one (1) of 105 sampled residents, facility staff failed to show documented evidence that a pharmacist performed a monthly medication review for Resident #150, from 01/23/23 through02/23/23. (Resident #150) The findings included: Review of the facility policy titled "Medication Regimen Review" with a revision date of 02/01/22 documented, " ...The pharmacist shall document either manually or electronically, that each medication regimen review has been completed. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities ...Written communications from the pharmacist shall become a permanent part of the resident's medical record ..." 1. Resident #150 was admitted to the facility on 02/22/18, with multiple diagnoses that includedthe following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, and Unspecified Dementia. A review of the medical record revealed an Minimum Data Set (MDS) assessment dated 12/18/22 showing that the facility staff coded Resident #150 as having moderately impaired	F 756	1. R150 currently reside inthe facility with no ill effects noted. The pharmacist reviewed the resident's medication regimen on 1/6/23 and 2/7/2023 with no recommendations given and assessment is documented in PCC. 2. The Director of nursing or designee will review the medical record for current residents in the facility to ensure that the pharmacist has performed a monthly medication review for the residents in the last 30-days. All residents have the potential to be affected. Findings indicated that all residents were reviewed and recommendations were made as appropriate. 3. The Nurse educator or designee will in service the pharmacy consultant to ensurethat a monthly medication review is performed on all residents every month. Facility has identified an alternative pharmacy consultant to provide monthly reviews. Reviews with no recommendations will be identified in residents' medical records and any recommendations will be followed up with physician and any new order will be noted in the medical record. 4. The Director of nursing or designee will audit 20% of the facility census to ensure that a monthly medication review is performed on all residents every month. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.	6/9/2023

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F 756	Continued From page 123 cognition. The facility staff coded that the residentreceived antidepressant medication. The medical record lacked documented evidencethat the pharmacist performed a monthly medication review during the months of January and February 2023. During a face-to-face interview conducted on 03/09/23 at approximately 1:00 PM, Employee #52 (Assistant Director of Nursing) stated that she prints out the monthly medication reviews each month and there is not one for the residentfor January and February 2023. Cross Reference 22B DCMR sect. 3224.3 (a)	F 756		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidencedby: Based on review of a facility reported incident, medical records, facility documentation, and interviews with family members and staff, for four (4) of 101 sampled residents, the facility's staff failed to 1. safely administer medications in accordance with Standard of Practice or Manufactures Specifications as evidenced by (1) Employee #22 (Agency Registered Nurse; RN) administered one unit of Novolog R insulin to Resident #313 without a physician's order on 02/10/23, (2) Employee # 25 (Agency RN) signedthat he administered medication to Resident #494who had no medication in the facility, (3) Employee #11 (RN) administered Resident #5 a	F 760		

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F 760	Continued From page 124 deceased resident's (Resident #488) medication (Gabapentin), and (4) storing and administering expired Humalog (Lispro) insulin medication to Resident # 7. Due to these failures, an Immediate Jeopardy situation was identified on February 17, 2023, at 4:17 PM. The facility submitted a Plan of Action tothe survey team that was on onsite at 2:21 AM onFebruary 18, 2023, and the plan was accepted. The survey team returned on February 21, 2023,to validate the facility's plan, and the Immediate Jeopardy was lifted on February 22, 2023, at 6:40PM. After removal of the immediacy, the deficientpractice remained at a potential for harm and thescope and severity was lowered to an E. The findings included: 1. As per the National Institute of Health, "Nursing Rights of Medication administration" [Last updated on 09/05/22], documented, "Nurses havea unique role and responsibility in medication administration, in that they are frequently the finalperson to check to see that the medication is correctly prescribed and dispensed before administration.it is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' ... The five traditional rights of medications administration included: "Right patient - ascertaining that a patient being treated is, in fact,the correct recipient for whom medication was prescribed. Right drug - ensuring that the medication to be administered is identical to the drug name that was prescribed. Right Route - Medications can be given to patients in many different ways, all of which vary in the time it	F 760	1. R313 had no ill effects. was assessed by medical director on 2/13/23. E22 was educated on the spot. E9 was educated on following parameters when administering medications and appropriate documentation. R494 had no ill effects. Resident was assessed on 2/13/23 by Nurse Practitioner. E25 was educated on following parameters when administering medications and the process for obtaining medications for medication administration when meds are not available. R224 was assessed on 2/16/23 by charge nurse, resident received right medication and right dose. E34 was educated on the process for obtaining medications for medication administration when meds are not available. R5was assessed and had no ill effects. R7 was assessed on 2/27/23 by Nurse Practitioner. E11 educated on obtaining medications for medication administration if not in facility and theprocess to review expiration date of insulins prior to use and assuring thatinsulin is stored appropriately. 2. All medication carts were checked to assure that no expired insulin nor discharged residents' medications were noted in medication carts. Licensed professional nursing including agency staff was educated on 2/22/23 on the seven (7)	6/9/2023

rights of medication administration, storage of insulin and the process for obtaining medications for medication administration when meds are not available. All residents have the potential to be affected. Findings showed that no medication error occurred, and that medications were properly stored.

3.Licensed professional nursing staff are being educated on the seven rights of medication administration, storage of insulin and the process for obtaining medications for medication administration when meds are not available by the Staff Educator or designee.

4.Weekly audits x 4 then monthly x3 will be completed by pharmacy consultant/designee of all medication carts to assure that no expired insulin nor discharged residents' medications were noted in medication carts until compliance is achieved.

Random observations will be conducted by unit manager/designee of Licensed professional nursing staff including agency staff to assure that staff is following the seven rights of medication administration and utilizing appropriate storage for insulin and following appropriate process for obtaining medications for medication administration when meds are not available. Observations will be weekly x4, then monthly x3 or until compliance is achieved. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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F 760	Continued From page 125 takes to absorb the chemical, time it takes for thedrug to act, and potential side-effects based on the mode of administration. Right time - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain atherapeutic effect or level. Right dose - Incorrect dosage, conversion of units, and incorrect substance concentration are prevalent modalitiesof medication administration error." https://www.ncbi.nlm.nih.gov/books/NBK560654/ A review of the facility's policy titled, "Medication Administration dated 02/01/22 revealed the staff was to "Identify residents by photo in the MAR (Medication Administration Record) ...review MARto identify medication to be administered ...compare medication source (bubble pack, vial,etc.) with MAR (Medication Administration Record) to verify resident name, medication name, form, dose , route, and time ...administer medication as ordered ...sign MAR after administered ... correct any discrepancies and report to the nurse manager ..." As per NovoLog fact sheet, "NovoLog is a man-made insulin used to control high bloodsugar in adults and children with diabetes mellitus." https://www.mynovoinsulin.com/insulin-products/novolog/home.html#:~:text=NovoLog%C2%AE%20is%20a%20rapid,with%20a%20long%2Dacting%20insulin. Resident #313 was admitted on 11/11/22. A review of the resident's medical record revealedthe resident had the following diagnoses: Parkinson's Disease, Neurocognitive Disorder	F 760		

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F 760	Continued From page 126 with Lewy Body, Adjustment Disorder with Anxiety, Dementia, Aftercare following Surgery ofSkin and Subcutaneous Tissue, Dysphagia-Oropharyngeal Phase, Cognitive Communication Deficit, Difficulty Walking, Generalized Muscle Weakness, Unspecified Elevated White Blood Cell Count, Unspecified Thrombocytosis, Essential Primary Hypertension, Constipation, Bradycardia, Pressure Ulcer of Sacral Region (Stage 4). The medical record lacked documented evidencethat the resident had a diagnosis or history of Diabetes Mellitus. Review of the resident's medication orders from 11/01/22 to 02/10/23 showed the following (active) medications were ordered for the resident: Active Medications -Percocet tablet 5-325 - give 1 tablet by mouthevery 8 hours as needed for chronic sever pain(7-10) (start date 11/11/22). -A-1000 (Vitamin A) capsule 3 mg (milligrams)- give 1 capsule by mouth one time a day for supplement (start date 11/12/22). -Amlodipine Besylate tablet 10 mg - give 1 tabletby mouth one time a day for hypertension (start date 11/12/22). -Ascorbic Acid tablet 500 mg - give 1 tablet by mouth two times a day for Parkinson's Disease(start date 11/12/22). -Carbidopa-Levodopa tablet 10-100 mg - give 1 tablet by mouth three times a day for Parkinson'sDisease (start date 11/12/22). -Rivastigmine Patch 24-hour 4.6 MG/24HR (hour)- apply 1 patch transdermally one time aday for Dementia (start date 11/12/22). -Vitamin E capsule 180 mg (400 unit) - give 1 capsule by mouth one time a day for supplements	F 760		

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F 760	Continued From page 127 (start date 11/12/22). -Mirtazapine tablet 7.5 mg - give 1 tablet by mouth at bedtime for appetite stimulant (startdate 02/07/23). -Dextrose with Sodium Chloride Solution 5-0.45% times 3 liters every shift (02/10/23). A Facility Reported Incident (FRI) dated 02/10/23 (DC00011664) documented, "On February 10, 2023, at approximately 7:46 PM an alleged medication error was reported. It was communicated that agency (contracted staff) nurse [Employee #22] obtained [Resident #313's]blood sugar level and administered 1 unit of Novolog R [insulin] without a doctor's order ... A nurse completed a full assessment. There was no evidence of hypoglycemia ...The provider was notified. New orders were given to check [Resident's name blood sugars every 6hrs (hours) and obtain vital signs every 4hrs for two days. Prior to the incident, [Resident #313] was receiving D5 1/2 at 75cc/hr (cubic centimeter/ hour) due to poor intake. [Resident 313] has not shown any signs or symptoms of hypoglycemia since the incident occurred. Nor has she shown any other negative outcomes as a result of insulinadministration ... Based on the full investigation and witness statement the facility substantiates that a medication error occurred ..." A review of Employee #22's (RN) written "Witness statement" signed on 02/10/23 documented, "Writer checked FS (fingerstick) of resident (Resident #313) and result was 163 mg/dl (milligram per deciliter). 1 unit of insulin given. The daughter was in the room at the time of the incident. She started questioning when her mother started getting insulin. Writer checked thePCC (Point Click Care - Electronic Medical	F 760		

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F 760	Continued From page 128 Record) there was no order [for Novolog R insulin] ..." During a face-to-face interview on 02/13/22 at approximately 9:30 AM, Employee #2 (Director of Nursing; DON) stated that Employee #22 administered 1 unit of Novolog R insulin to Resident #313 on 02/10/23 without a physician order. The DON said Employee #22 was removed from the unit. And the resident was assessed and there were no ill effects from the insulin. In addition, the DON stated that she wentto the resident's bedside and apologized to the daughter on 02/10/23. During a telephone interview conducted starting at 9:50 AM on 02/15/23, the resident's daughter stated, "The nurse (Employee #22) came into theroom and pricked my mom's finger. I asked the nurse why she pricked my mom's finger. The nurse said she was checking my mother's blood sugar level. When she checked my mom's blood sugar, she said it was 163, which was slightly high. My friend who was with me said to the nursethat my mom just finished eating, that's why her blood sugar was high. The nurse said it wouldn't affect her because she's only getting 1. I can't remember if the nurse informed me, she gave 1 milligram or 1 unit." 2. On 02/10/23, for Resident #494, Employee #9 (Agency RN) failed to safely administer medications as evidenced by not following: special instructions (hold for diastolic blood pressure less than 60 millimeters of mercury) when administering Hydralazine and Carvedilol; Standards of Practice by not ensuring Resident #494 received the prescribed dose of Hydralazine(anti-hypertensive medication); and Standards of	F 760		

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F 760	Continued From page 129 Practice by documenting medications as being administered that were not administered. As per the National Institute of Health, "Quality Indicators for Safe Medication Preparation and Administration. A Systemic Review" [Published on 04/17/15] documented, "To ensure safe medication preparation and administration, nurses are trained to practice the "7 rights" of medication administration: right patient, right drug, right dose, right time, right route, right reason, and right documentation. However, adhering to these 7 rights is not just the responsibility of the individual nurse, but also of the health care organization..." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4401721/#:~:text=To%20ensure%20safe%20medication%20preparation,documentation%20%5B12%2C%2013%5D. Resident #494 was readmitted to the facility on 02/09/23. The resident had multiple diagnoses including Essential Hypertension, Cerebral Infarctions without Residual Deficit, Alcohol Abuse, and Anemia. 2a. Employee #25 (Agency RN) failed to follow special instructions (hold for diastolic blood pressure less than 60 millimeters of mercury) when administering Hydralazine and Carvedilolfor Resident #494. On 02/10/23 at approximately 10:00 AM, a reviewof Resident #494's electronic Medication Administration Record (MAR) revealed Employee#25 administered Resident #494 Hydralazine 25 mg (milligrams) and Carvedilol 6.25 mg at 8:00 AM. Further review of the MAR revealed the resident's diastolic blood pressure was 56.	F 760		

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F 760	Continued From page 130 Review of the resident's medical record revealedthe following physician orders, "Hydralazine 25 mg -give 1 tablet by mouth every 8 hours for HTN (hypertension). Hold for SBP (systolic blood pressure) < 110 mm/HG (millimeters of mercury) - DB/P (diastolic blood pressure) < 60 mm/HG." "Carvedilol 6.25 mg - give 1 tablet by mouth two times a day for heart attack prevention Hold for SBP (systolic blood pressure) < 110 mm/HG (millimeters of mercury) - DB/P (diastolic blood pressure) < 60 mm/HG." During a face-to-face interview on 02/10/23 at approximately 10:30 AM, The surveyor asked Employee #25 why did he administer the resident Hydralazine 25 mg (milligrams) and Carvedilol 6.25 mg when his diastolic blood pressure was less than 60? Employee #25 failed to provide ananswer. On February 10, 2023, at approximately 10:40 AM, Resident #494 was observed in his room lying in bed. The resident was alert and orientedto name, date, and place. A review of Resident #494's vital signs sheet revealed the resident's diastolic blood pressure ranged from 56mm/HG to 78 mm/HG on 02/10/23 from 8:56 AM to 9:59 PM. 2b. Employee #25 (Agency RN) failed to Follow Standards of Practice as evidenced by not ensuring Resident #494 received the prescribeddose of Hydralazine (anti-hypertensive medication). An observation of Unit 2 North's Team III's medication cart 02/10/23 starting at	F 760		

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F 760	Continued From page 131 approximately 10:00 AM revealed Resident #494's section did not have any medications. At the time of the observation, the surveyor reviewedthe resident's electronic Medication Administration Record that showed Employee #25 administered Hydralazine 25 mg on 02/10/23at 8:00 AM. Employee #25 was asked by the surveyor, how did he administer Hydralazine Resident #494 if there were medications the resident's section. Employee #25 stated, "I use another resident's Hydralazine." The employee then showed the surveyor the other resident's blister pack of Hydralazine 50 mg. The surveyor asked Employee #25 did he administer 50 mg of Hydralazine because 25 mg was ordered. The employee said, "No, I gave 25mg." The employee then proceeded to remove an unscoredhydralazine 50 mg tablet (that was not scored with a mark indicating where to split it) from the other resident's blister pack. Employee #25 used his hands to break the tablet into two pieces. Thetablet was not broken evenly. The surveyor asked, how did he ensure the resident received the prescribed dose, if the pieces of the tablet were not broken evenly. Employee #25 failed to provide an answer. In addition, Employee #25 was asked if he could have retrieved the Hydralazine from the facility's stock medication system. Employee #25 stated, "Yes, but becauseI'm an agency nurse I don't have a code to use the system. I must ask the supervisor, unit manager or a staff nurse to get the medication forme." Review of the resident's medical record revealedthe following a physician order, "Hydralazine 25 mg - give 1 tablet by mouth every 8 hours for HTN (hypertension). Hold for SBP (systolic blood pressure) < 110 mm/HG (millimeters of mercury)	F 760		

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F 760	Continued From page 132 - DB/P (diastolic blood pressure) < 60 mm/HG." Per the Food and Drug Administration, "Best Practices for Tablet Splitting", documented, "When considering whether to split a tablet, you and your healthcare professional should bear in mind the following: If a tablet is FDA-approved tobe split, this information will be printed in the "HOW SUPPLIED" section of the professional label insert and in the patient package insert. Also, the tablet will be scored with a mark indicating where to split it. If a tablet does not include such information in the label, FDA has notevaluated it to ensure that the two halves of a split tablet are the same in weight or drug contentor work the same way in the body as the whole tablet. You should discuss with your healthcare professional whether to split this type of tablet." https://www.fda.gov/drugs/ensuring-safe-use-me dicine/best-practices-tablet-splitting Review of the "HOW SUPPLIED" section of the professional label insert for Hydralazine Hydrochloride lacked documented evidence onhow to split Hydralazine tablets. https://www.accessdata.fda.gov/drugsatfda_docs/ label/1996/008303s068lbl.pdf An observation of Unit 2 North's Omnicell on 02/10/23 at approximately 10:30 AM revealed the system contained Hydralazine 25mg tablets. However, the system failed to show the medication was removed for Resident #494. During a face-to-face interview on 02/10/23 at approximately 10:35 AM, Employee #24 (RN/ UnitManager) stated that Employee # 25 was not	F 760		

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F 760	Continued From page 133 given Resident #494 another resident's medication. He should have asked her or the supervisor to remove it from the Omnicell. 2c. Employee #9 (Agency RN) failed to follow Standards of Practice for Resident #494 on 02/10/23 as evidenced by documenting medications as being administered that were notadministered. An observation of Unit 2 North's Team III's medication cart on 02/10/23 starting at approximately 10:00 AM revealed Resident #494's section was empty. During a face-to- face interview at the time of the observation, Employee#24 (RN-Unit Manager) stated that the resident was re-admitted on afternoon of 02/09/23. The resident medication had been ordered from the pharmacy, but the medication had not been delivered to the facility. A review of the resident's electronic Medication Administration Record at the time of the observation revealed Employee #25 (Agency RN)initialed several medications indicating that he had administered the medications listed below asfollowed: Aspirin [non-steroidal anti-inflammatorydrug] 81 mg (milligrams) one tablet, Multivitamin [vitamin] adult one tablet, Nifedipine ER (extended release) 30 mg one tablet, Potassium Chloride [electrolyte supplement] ER 20 MEQ (milliequivalents) one tablet, Thiamine [vitamin] HCI (hydrochloride) 100 mg one tablet, Valsartan[angiotensin II receptor blocker] 80 mg one tablet,Carvedilol [beta blocker]6.25 mg one tablet, Heparin Sodium[anticoagulant] 5000 unit/ml (milliliter) one vial intramuscularly, and Hydralazine [vasodilator] HCI 25 mg one tablet.	F 760		

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F 760	Continued From page 134 During a face-to-face interview on 02/10/23 at 10:50 AM, Employee #25 stated that he only administered Hydralazine and Carvedilol. When asked, how did he give the resident blood pressure if the resident did not have medication inthe cart, Employee #25 stated, "I used other residents' medications because the resident asked for [pro-noun] blood pressure medication." When asked, why did he initial that he had administered the other medications, he said, "I signed in error, but I only gave Hydralazine and Carvedilol." 3. The facility's staff failed to ensure Resident#224 did not receive a deceased resident's [Resident #488] medication. Resident #224 was admitted to the facility on 02/16/2021 with multiple diagnoses that included: Neuralgia and Neuritis, Hypertension, Muscle Weakness, Seizures, Major Depressive Disorderand Acute Kidney Failure. A review of Resident #224's medical record revealed a Physician's Order dated 03/24/21 thatdocumented "Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth one time aday for Neuropathic Pain." A review of Residents #224's February 2023 Medication Administration Record (MAR) revealed the following order, "Gabapentin Capsule 300 MG (milligrams) - give 1 capsule bymouth one time a day for Neuropathic Pain at 9:00 AM." Continued review of the MAR showedstaff initials from 02/01/23 to 02/12/23 (why not 02/10/23) indicating Resident #224 was administered Gabapentin at 9:00 AM on the aforementioned dates.	F 760		

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An observation on 02/10/23 at 10:16 AM of Unit 2 South's Team 1's medication cart revealed Resident #224's assigned section contained Resident #488's blister pack of Gabapentin 300 milligrams.

During a face-to-face interview on 02/10/23 at 10:16 AM, Employee #34 (RN) was asked why Resident #488's Gabapentin blister pack was in Resident #224's assigned medications section. The employee stated, "I'm not sure, but I know that it's his [medication]." The employee was thenasked did she administer Resident #224's Gabapentin 300 milligrams on this date, 02/10/23,at 9:00 AM, and Employee #34 said, "Yes."

During a face-to-face interview on 03/10/23 at 6:20 PM, Employee #27 (ADON) was asked whatprocesses are in place for nursing staff to ensurethere are no medication errors. The employee stated, "Beginning of shift change, the nursing staff check all medication carts to make sure medications aren't mixed with other residents."

4. The facility's staff failed to follow Manufactures specifications for storing and administering expired Humalog (Lispro) insulin medication for Resident #7.

Review of the manufacturer's specifications for Humalog (Lispro), section "Storage and Handling," documented, "Do not use after the expiration date ... In-use insulin Lispro vials ... must be used within 28 days or be discarded, even if they still contain insulin ..." https://pi.lilly.com/us/insulin-lispro-uspi.pdf

Review of the facility's policy entitled, "Medication

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F 760	Continued From page 136 Errors," dated 02/02/22, documented, " ...The facility shall ensure medications will be administered as follows ...Per manufacturer's specifications regarding the preparing, and administration of the biological ... In accordancewith accepted standards and principles ..." Review of Resident #7's medical record revealedthat the Resident was admitted to the facility on 09/12/12 with diagnoses including: Type 2 Diabetes Mellitus, Hemiplegia and Hemiparesis,Traumatic Brain Injury, and Generalized Muscle Weakness. A Physician's Order dated 11/09/22 at 11:00 AM directed: "Insulin Lispro Solution 100 unit/ml, inject as per sliding scale: If 151-200 =1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 4 units; 351-400 = 5 units, Call MD/NP (Medical Doctor/Nurse Practitioner. If blood sugar is less than 60 or over 400, subcutaneously before meals and at bedtime for DM@ (Type 2 DiabetesMellitus)." Review of the Resident's medical record revealeda Quarterly Minimum Data Set (MDS) with an assessment dated 02/14/23 which documented the resident had a Brief Mental Status (BIMS) Summary Score of, "15," indicating the Resident had intact cognition. The resident was also codedfor using insulin. Review of the Resident #7's Medication Administration Record (MAR) for February 2023 showed that staff administered the resident expired insulin on nine (9) occasions after the expiration date of 02/16/23, as follows: On 02/17/23 at 8:00 AM - 1 unit of insulin was	F 760		

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F 760	Continued From page 137 administered for a blood sugar of 186 mg/dl. On 02/17/23 at 11:00 AM - 1 unit of insulin was administered for a blood sugar of 167 mg/dl. On 02/17/23 at 6:00 PM - 2 units of insulin were administered for a blood sugar of 244 mg/dl. On 02/17/23 at 9:00 PM - 2 units of insulin were administered for a blood sugar of 244 mg/dl. On 02/18/23 at 6:00 PM - 1 unit of insulin was administered for a blood sugar of 199 mg/dl. On 02/19/23 at 6:00 PM - 1 unit of insulin was administered for a blood sugar of 167 mg/dl. On 02/20/23 at 6:00 PM - 1 unit of insulin was administered for a blood sugar of 162 mg/dl. On 02/20/23 at 9:00 PM - 1 unit of insulin was administered for a blood sugar of 162 mg/dl. On 02/21/23 at 8:00 AM - 1 unit of insulin was administered for a blood sugar of 167 mg/dl. It should be noted Resident #7's medical record lacked documented evidence that the resident had any adverse effects from receiving insulin during this period. An observation on 02/22/23 at 4:38 PM on Unit 1 South showed that inside the top drawer of the medication cart labeled "Team 1" contained a vialof expired Humalog (insulin) 100 unit/ml (milliliters) that was marked with Resident #7's name. Written on the vial of insulin was an "opendate of 01/19/23 and an expiration date of 02/16/23." During a face-to-face interview at the time of the observation, Employee # 9 (Registered Nurse) stated that the last time Resident#7 received Humalog (Lispro) insulin was at 8:00 AM on 02/21/23 for a blood sugar of 167 mg/dL (milligrams per deciliter). During a face-to-face interview on 02/21/23 at 4:57 PM, Employee #9 (Registered Nurse) stated	F 760		

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F 760	Continued From page 138 most insulin vials are used for 28 days once they are opened; unopened insulin vials are stored in the medication refrigerator. When insulin vials arefirst opened, the Nurse writes the open and expiration dates along with their initials on the bottle. When asked about the vial of insulin labeled with Resident #7's name, the Employee stated, "I inspected the medication cart yesterday,and the vial of expired insulin was not there." Employee #9 then searched the unit's medicationstorage room, the medication refrigerator, and thetwo other medication carts and did not locate anyadditional vials of insulin for Resident #7. During a face-to-face interview on 02/21/23 at approximately 5:00 PM, Employee #23 (1South Unit Manager) stated that one to two (1-2) days before a resident's insulin expires, the Nurse reorders a new vial of insulin from the pharmacy.Employee#23 searched the medication refrigerator in the medication storage room for 1South and did not locate any new or unopened vials of insulin for Resident #7. The Employee reviewed the Resident's February MAR and acknowledged that the nursing staff had documented that insulin was administered to theResident after 02/16/23. The Employee did not provide evidence that a new vial of insulin was reordered for the Resident after 02/16/23 and made no further comments. Based on these findings, on February 17, 2023, at 4:17 PM, an Immediate Jeopardy (IJ)-"J" situation was identified. On February 18, 2023, at2:21 AM, the facility's Clinical Executive Directorprovided a corrective action plan to the State Agency Survey Team, which was accepted. Theplan included:	F 760		

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F 760	Continued From page 139 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to addressthe citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 2/20/23). a). Resident R2 [Resident #313] who received the insulin medication was immediately monitored with no adverse effects noted. Resident remainedstable. Employee #8 [Employee #22] was educated on the spot on 02/10/23 for administering insulin without physician order and on the "7" Rights of Medication Administration. Employee #8 [Employee #22] was removed from schedule and facility. Employee #8 [Employee #22] was placed on the "Do Not Return" List. b). Resident R3 [Resident #494] was evaluated and no negative effect was noted. E9 [Employee#25] was educated on 02/10/23 about medicationadministration and Omnicell availability for meds.c). Resident R5 [Resident #224] did not have anyadverse effect from med administration; E11 [Employee #34] was-educated on the spot regarding appropriate process for medication notavailable - for administration and not utilizing medications from a deceased resident. 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to preventany adverse outcome from occurring. (Completions date: 2/20/23). -All applicable facility practices related to medication administration, medication storage and/or ordering medications for new admissionswere reviewed/revised. -The DON or designee re-educated licensed nurses on facility practices regarding medicationadministration, medication storage and/or ordering and reordering medications for new	F 760		

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F 760	Continued From page 140 admissions and reconciliation guidelines. Education initiated for nurses beginning 2/18 through compliance date. -The DON or designee will complete corrective action or one-to-one education on above listed topics with licensed nurse(s) identified as being deficient in their practice resulting in this citation. The DON or designee will educate all licensed and contractual nurses who work on 2/18 throughcompliance of this plan, on medication administration, ordering medications and reordering medication and disposition of medication guidelines. The DON or designee audited all residents by to identify if any other residents were administered insulin without a physician order and all new admission residents had medications in the cart that was ordered by 2/12/23. All deceased residents' medications were return to pharmacy. 3. The audit will continue until compliance can be maintained for 3 consecutive months. 4. The Administrator or designee implemented a QAPI PIP as a means to gather and process information from the audit. Findings will be reported at the monthly QAPI meeting for a minimum of 3 months. Date Facility Asserts Likelihood for Serious Harmno Longer Exists: 2/20/23 The survey team verified implementation of theplan and the immediate jeopardy was lifted on February 22, 2023 at 6:40 PM. Cross refernece 22B sect. 3211.1(a)	F 760		
F 761 SS=K	Label/Store Drugs and Biologicals	F 761		

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F 761	Continued From page 141 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must belabeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs andbiologicals in locked compartments under propertemperature controls, and permit only authorizedpersonnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II ofthe Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose canbe readily detected. This REQUIREMENT is not met as evidencedby: Based on review of a facility reported incident, medical records, facility documentation, and family and staff interviews, for six (6) of 104 sampled residents, the facility's staff failed properly store medications in accordance with Standards of Practice or Medication Manufacturer's Specifications as evidenced by: (1) not ensuring Resident #7's individual medication compartment did not contain expiredHumalog (Lispro) insulin. Subsequently, the	F 761	1.R7, R 224, R79, R 147, R155, R219, R6 currently reside in the facility and have no ill effects at this time. R7 expired Insulin Lispro was immediately disposed of on 2/10/23 and replaced on 2/11/23. R7 was assessed on 2/11/23. E34 was educated on removing any medications for dischargedresidents from the medication cart and no longer comes to the facility. E15, E16, E17, E34, E33 were educated on removing any medications that did not belong to resident from individual medication compartment. R224- Gabapentin belonging to R488 was immediately removed from the cart and Gabapentin ordered STAT on 2/10/2023 and was delivered on 2/11/2023. R224 was assessed on 2/16/23 by the charge nurse. Only medications belonging to R224 are present in his individual medication compartment as of 2/10/23. R79- the atorvastatinbelonging to resident number R488 was immediately removed from the cart on 2/10/23. Medication ordered STAT and was delivered on 2/11/2023. R79 was assessed on 2/15/23 by Nurse practitioner. Only medication belonging to resident R79 is present in her individual medication compartment as of 2/10/23.	06/09/2023

R147 Novolog R insulin was immediately discarded on 2/10/23, and re- ordered STAT and delivered on 2/11/23. R147 was assessed by the nurse practitioner on 3/7/23. E35 was educated on proper medication storage and not to share or borrow medication from other residents. New Novolog R insulin delivered on 2/11/23.

R155-The Sevelamerbelonging to R232 was immediately removed. R155 was assessed by the nurse practitioner on 2/27/23. Medications belonging to R155 are present in his individual medication compartment as of 2/10/23.

R219- Donepezilbelonging to R95 was immediately removed. Resident was assessed on 2/27/23 by the physician. Only medications belonging to R219 are present in his individual medication compartment as of 2/11/23.

R6- Loperamide belonging to resident R116 was immediately removed. Resident was assessed on 2/27/23 by the physician. Only medications belonging to R6 are present in her individual medication compartment as of 2/10/23.

2. The Director of nursing or designee verified that the current resident’s medications are properly stored in accordance with standards of practice on that expired medications are disposed of appropriately, that discharge medications are disposed of per protocol and that medication compartments of each resident do not have other resident's medications,and that medications are re-ordered timely.
All residents have the potential to be affected.
Findings indicated that there were a few residents with medications in the incorrect medication slots which were removed on 5/22/23. Medications were disposed of appropriately per standard and medications were ordered in a timely fashion.

3. The Nurse educator or designee will in service the licensed professional nurses toensure that the residents' medications are stored properly in accordance with current standards of practice, that expired medications are disposed of appropriately,
that discharge medications are disposed ofper protocol, that medication compartments
of each resident have only those medications that are ordered for that resident, and that medications are re-ordered timely.

4. The Pharmacy consultant/designee will audit medication carts to ensure that the residents' medications are properly stored in accordance with standards of practice, that expired medications are disposed of appropriately, that discharge medications are disposed of per protocol, that medication compartments of each resident do not have other residents' medications, that medications are re-ordered timely. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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F 761	Continued From page 142 resident was administered expired Humalog (Lispro) insulin, (2) Employee #34 failed to ensureResident #224's individual medication compartment did not contain a deceased resident's [Resident #488] medication, Subsequently the resident was administered the deceased resident's medication [Gabapentin], (3)Employee #35 stored Resident #147's Novolog insulin in her uniform pocket, (4). Employee #15 failed to ensure Resident #155's individual medication compartment did not contain Resident#232's medication. (5) Employee #16 failed to ensure Resident #219's individual medication compartment did not contain Resident #95's medication, (6) Employee #17 failed to ensure Resident #6's individual medication compartment contained Resident #116's medication. Due to these failures, an Immediate Jeopardy situation was identified on February 17, 2023, at 4:17 PM. The facility submitted a Plan of Action tothe survey team that was on onsite at 2:21 AM onFebruary 18, 2023, and the plan was accepted. The survey team verified implementation of the plan on February 24, 2023, at 12:40 PM and at the immediate jeopardy was lifted. After removal of the immediacy, the deficient practice remainedat a potential for harm and the scope and severitywas lowered to a E. The findings included: 1. Review of Resident #7's medical record revealed that the Resident was admitted to the facility on 09/12/12 with diagnoses including Type2 Diabetes Mellitus, Hemiplegia and Hemiparesis,Traumatic Brain Injury, and Generalized Muscle Weakness.	F 761		

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F 761	Continued From page 143 Review of the manufacturer's specifications for Humalog (Lispro), section "Storage and Handling," documented, "Do not use after the expiration date ... In-use insulin Lispro vials ... must be used within 28 days or be discarded, even if they still contain insulin ..." (https://pi.lilly.com/us/insulin-lispro-uspi.pdf) A review of physician's orders dated 11/09/22 at11:00 AM directed: "Insulin Lispro Solution 100unit/ml, inject as per sliding scale: If 151-200 =1unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 4 units; 351-400 = 5 units, Call MD/NP (Medical Doctor/Nurse Practitioner. If blood sugaris less than 60 or over 400, subcutaneously before meals and at bedtime for DM@ (Type 2 Diabetes Mellitus)." During a face-to-face interview on 02/21/23 at 4:57 PM, Employee #9 (RN) stated that insulin vials are used for 28 days once they are opened.When insulin vials are first opened, the Nurse writes the opened and expiration dates along withtheir initials on the bottle. When asked about the vial of insulin labeled with Resident #7's name, Employee #9 stated, "I inspected the medication cart yesterday (02/20/23), and the vial of expiredinsulin was not there." Employee #9 then searched the unit's medication storage room, the medication refrigerator, and the two other medication carts and did not locate any additionalvials of insulin for Resident #7. An observation on 02/22/23 at 4:38 PM of Unit 1South Team 1's medication cart revealed a vial ofexpired Humalog (insulin) 100 unit/ml (milliliters) that was marked with Resident #7's name. Written on the vial of insulin was an opened dateof 01/19/23 and an expiration date of 02/16/23.	F 761		

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Cross reference F760.

2. Resident #5 was re-admitted to the facility on 03/24/21 with multiple diagnoses including neuralgia and neuritis.

Review of Resident #5's physician's order revealed an order dated 03/25/21 documenting,"Gabapentin 300 mg (milligrams) by mouth onetime a day for neuropathic pain."

An observation of Team 2's medication cart on Unit 2 south on 02/10/23 at approximately 10:00 AM revealed Resident #224's medication sectionincluded a blister pack of Gabapentin 300 mg belonging to Resident #488. The medication cartlacked evidence of Gabapentin for Resident #224at the time of the observation.

A review of Residents #224's February 2023 Medication Administration Record (MAR) revealed the following order, "Gabapentin Capsule 300 MG (milligrams) - give 1 capsule bymouth one time a day for Neuropathic Pain at 9:00 AM." Continued review of the MAR showedEmployee #34 initialed that she administered Resident #224 Gabapentin on 02/10/23 at 9:00 AM.

During a face-to-face interview on 02/10/23 at 10:16 AM, Employee #34 (RN), was asked whyResident #488's Gabapentin blister pack was inResident #224's assigned medications section. The employee stated, "I'm not sure, but I know that it's his." The employee was then asked did she administer Resident #224's Gabapentin 300milligrams on this date, 02/10/23, at 9:00 AM. Employee #34 said, "Yes." It should be noted

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F 761	Continued From page 145 Resident #488 was discharged from the facility in December of 2022. Cross reference F 760. 3. Resident #79 was admitted to the facility on 07/22/2021 with multiple diagnoses that included Hyperlipidemia, Hypertension, Type 2 Diabetes,and Morbid Obesity. Review of Resident #79's medical record revealed a physician's order dated 12/25/2022that documented, "Lipitor Tablet 40 MG (milligrams)- give 1 tablet orally at bedtime for Hyperlipidemia." An observation on 02/10/23 at 10:48 AM of Unit 2 South Team 1's medication cart revealed Resident #79's individual medication section contained Resident #488's opened blister pack ofAtorvastatin [lipid-lowering agent] 40 milligrams with five 5 of 30 tablets remaining in the blister pack. During a face-to-face interview on 02/10/2023 at 10:51 AM, Employee #33 (Agency Licensed Practical Nurse; LPN) was asked if she knew whyResident #79's individual medication section contained Resident #488's Atorvastatin. Employee #33 stated, "No, I don't know why; I didn't notice it. I didn't give it, I work the day shift, she gets it at night." Employee #33 then reportedthat Resident #488 was discharged in December[2022] to the hospital, and she believed the resident passed while in the hospital. In addition,the employee could not explain why Resident #488's medication was still in the medication carton 02/10/23, and stated, "It should not be there."	F 761		

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F 761	Continued From page 146 During a face-to-face interview on 03/10/23 at 6:20 PM, Employee #27 (Assistant Director of Nursing; ADON) was asked what processes werein place for nursing staff to ensure there were nomedication errors. Employee #27 reported, "Beginning of shift change, they check all medication carts to make sure medications aren'tmixed with other residents." 4. Resident #147 was admitted to the facility on 12/20/20 with multiple diagnoses including Type 2Diabetes Mellitus. A review of the resident's medical record revealeda physician's order dated 10/20/22 that instructed, "Novolog 100 units/milliliters inject per sliding scale ...subcutaneously before meals and at bedtime". An observation on 02/13/23 at approximately 11:00 AM revealed Unit 2 South's Team #1, Team#2, and Team #3 medication carts did not containNovolog R insulin for Resident #147. Also, observation of the unit's medication refrigerator lacked evidence of Novolog R insulin for Resident#147. At the time of the observation, Employee #28 (Unit Manger/RN) stated that she did not seeNovolog R insulin for Resident #147 in the medication carts or the medication refrigerator. At approximately 11:30 AM on 02/13/23, Employee #28 came to the conference room andshowed the surveyor an open vial of Novolog R insulin for Resident #147. The employee stated, "The nurse [Employee #35] had it in her pocket. The nurse said after she administered insulin to the resident, she forgot to put it back in the medication cart."	F 761		

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F 761	Continued From page 147 During a face-to-face interview on 02/15/23 at approximately 4:00 PM, Employee #35 (RN) was asked if it was the Standard of Practice to store insulin in her uniform pocket. The employee stated, "No, I just forgot to put it back in the cart. Iwas so busy." 5. Employee #15 (LPN) failed to ensure Resident #155's individual medication compartment did not contain Resident #232's Sevelamer Carbonate (phosphate binder) medication. On 02/22/23 at approximately 4:00 PM, an observation of Unit 3 North's Team 2's medicationcart revealed Resident #155's individual medication compartment contained Resident #232's blister pack of Sevelamer Carbonate 800 milligrams. At the time of the observation, Employee #15 stated that the medication Sevelamer Carbonate was in the wrong resident'ssection. 6. Employee #16 (LPN) failed to ensure Resident #219's individual medication compartment did not contain Resident #95's Donepezil (cognition-enhancing) medication. On 02/22/23 at approximately 4:40 PM, an observation of Unit 3 North's Team 1's medicationcart revealed Resident #219's individual medication compartment contained Resident #95's blister pack of Donepezil 5mg. At the time of the observation, Employee #16 stated that theyhave residents with similar names and that the facility needed to do name alerts. 7. Employee #17 failed to ensure Resident #6's individual medication compartment did not contain Resident #116's Loperamide	F 761		

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F 761	Continued From page 148	F 761		

(anti-diarrheal) medication.

On 02/24/23 at approximately 10:00 AM, an observation of Unit 3 North Team 1's medicationcart revealed that Resident #6's individual medication compartment contained Resident #116's Loperamide (anti-diarrhea) 2 mg medication. At the time of the observation, Employee 17 (Agency Licensed Practical Nurse;LPN) stated that that medication Loperamide might have fallen from the top drawer into the wrong resident's section.

Based on these findings, on February 17, 2023, at 4:17 PM, an Immediate Jeopardy situation wasidentified. On February 18, 2023, at 1:00 AM, thefacility's Clinical Executive Director provided a corrective action plan to the State Agency SurveyTeam that was accepted. The plan included:

1. Immediate action(s) taken for the resident(s) found to have been affected include:

The medication/Novolog R insulin for Resident #147 was not stored properly and a new vial wasobtained from the freezer in medication room.
Employee #35 was educated on proper storageof medications and not to share or borrow medication from other residents.

Resident #224's, Gabapentin was ordered STAT from pharmacy on 02/10/23 with a limited quantityand reordered 02/17/23. Resident #488 was returned to the pharmacy.

2. Identification of other residents having the potential to be affected was accomplished by:

The facility has determined that all residents

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F 761	Continued From page 149 receiving insulin and Gabapentin medicationshave the potential to be affected. Dischargedresidents will be reviewed for disposition of medications. 3. Actions taken/systems put into place to reducethe risk of future occurrence include: An in-service education program will be initiated by the Director of Nursing or designee with staff and contractual staff (agency) nurses who are working in the facility from 2/18/23 to 2/20/23 to address the facility practices regarding the properstorage of medications, obtaining medications from Pharmacy based on MD orders and disposition of medications upon discharge. 4. How the corrective action(s) will be monitoredto ensure the practice will not recur: Unit managers or designee will inspect all medication carts and medication refrigerators daily X 2 weeks, then weekly X 2 weeks, then monthly X 3 for all medication: including insulinand Gabapentin medication, to ensure appropriate storage on an on-going basis. UnitManagers or designee will check medications cart to ensure that residents' medications are available based on MD orders and dischargedmedications are not in the carts. Findings of this audit will be discussed with the clinical IDT during clinical stand down meetings. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has beenmet. Corrective action completion date:2/20/23.	F 761		

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F 761	Continued From page 150 On February 22, 2023, the facility's Clinical Executive Director provided additional steps ofthe corrective action plan to the State AgencySurvey Team, which included: On 02/22/23, the facility has taken the fooling addition steps to remove the IJ for F761: -Nurses, including contractual nurses, who haven't received the in-services in person, continues to receive the education when they areonsite. -Clinical Executive Director, Director of Nursing and QA Nurse discussed the in-services' contentto detailed in the Plan of Correction/Allegation of Compliance forms to formulate a "competency posttest" to test for retention of education provided. -Clinical Executive Director developed the competency test. -QA Nurse or designee is leading the effort to ensure that all licensed nurses who are scheduled to provide direct nursing care on 7-3and 3-11 completes the test. -Education will be given by a clinical leader and/orStaff Development Coordinator for any questions that were answered incorrectly. -Competency test will continue to be given until 100% of licenses nurses are completed, including Nursing Administrative leaders and support staff (i.e.: MDS nurses). Date of Compliance: 02/22/23 On February 23, 2023, the facility's Clinical Executive Director provided additional steps ofthe corrective action plan to the State AgencySurvey Team, which included: -On 2/22/23, the facility has taken the following additional steps to remove the IJ for the F761	F 761		

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F 761	Continued From page 151 citation observed during the evening hours of 2/22/22 [23]. -Administrator, Director of Nursing and Clinical Executive Director had an ad hoc meeting to discuss issues found and the root cause of issues. -All med carts were immediately audited to ensure medications were stored in the correctspaces by the clinical management team. -Director of Nursing initiated an investigation withstaff members involved. Staff were interviewed. Statements will be obtained. -Facility leadership team developed a new process wherein nurses will validate, at the beginning of their shift, that all residents' medications are stored in the correct section of the cart (i.e., a residents' medication will be placed in their section only). The verification will be documented on the "Medication Verification Form." Further, nurses will verify via the Medication Verification Form that medications received from the pharmacy have been placed inthe appropriate section in the med cart. The verification form completion will start 3-11 on 2/23/23. -Inservice was initiated on the 3-11 shift on 2/23/23 to advise the staff nurses of the new medication verification process and being mindfulof where the medication is stored on the cart going forward via SMS communication. Educationwill be ongoing when the nurses are onsite, on allshifts. -Unit Clerks will be reminded that they must ensure that a "name alert" sticker is placed on theresidents' door name plate and chart to increase the awareness of the staff. Unit Clerks were educated per SMS communication and will continue onsite when they work. -DON contacted the pharmacy to see if there are	F 761		

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F 761	Continued From page 152 "name alert" stickers for the medication blister packs on 2/22/23. Pharmacy stated they were not. LNHA is researching other options to achievethis goal. Date of Compliance: 2/23/23 The survey team verified implementation of the plan while onsite on February 24, 2023, at 12:40PM and the immediate jeopardy was lifted. Cross reference 22B DCMR sect. 3227.12 and 3227.13	F 761		
F 803 SS=J	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established nationalguidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well asinput received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		

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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 803	Continued From page 153 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidencedby: Based on observations, record reviews, resident,and staff interviews, for one (1) of 98 sampled residents, the facility's staff failed to ensure Resident #255's menu was followed, as evidenced by not providing a pureed diet on 02/17/22. Subsequently, after eating approximately 10% of a biscuit that was providedby facility staff on 02/17/22, the resident complained of feeling the biscuit in his throat. Due to these failures, an Immediate Jeopardy situation was identified on February 17, 2023, at approximately 5:30 PM. The facility submitted a Plan of Action to the survey team that was on onsite at 2:21 AM on February 18, 2023, and theplan was accepted. The survey team verified implementation of the plan on February 21 - 22 2023. The Immediate Jeopardy was lifted on February 22, 2023, at 6:40 PM. After removal of the immediacy, the deficient practice remained atpotential for more than minimal harm that is not immediate jeopardy for all remaining residents, ata scope and severity of D. The findings included: Resident #255 was re-admitted to the facility on 01/25/23. The resident had a history of diagnoses including dysphagia following cerebral infarction, dysphagia oropharyngeal phase, gastro-esophageal reflux disease, acute gastriculcer without hemorrhage or perforation,	F 803	1.On February 17, 2023, R255's meal tray was removed and a meal appropriate for the resident's diet orders was provided by nursingstaff. No ill effects were noted. R255 was discharged fromthe facility on February 24, 2023, E13 was educated on following resident's prescribed order. 2.The Dietician/ designee reviewed current residents prescribed orders with tray card information to verify accuracy on 2/20/23. All Residents with altered diets have the potential to be affected. Findings showed that no resident with an altered diet received the wrong meal. 3. The Nursing Educator or designee will in-service the nursing,activities, and dietary staff to ensure that the residents' meal traytickets and the meals served are what is prescribed before they are served to each resident. 4. The DON or designee will audit daily x 7 days any new dietary orders to ensure the dietary orders are accurate in the medical record and match the resident's meal tray ticket. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	06/09/2023

The Dietary Manager or designee will monitor food preparation daily x 7 days to ensure the meal tickets match the prescribed orders prior to exiting the kitchen.

			Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	

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F 803	Continued From page 154 dysphonia, and Parkinson disease. 1a. Review of Resident #255's Physician Orders revealed an order dated 01/25/23 documenting, "Aspiration precautions every shift." A Nutrition Assessment dated 01/26/23 at 1:07PM documented, " ...Puree diet, resident tolerating well, however, prefers upgrade, rec (recommend) slp (speech therapy) screen as needed ..." A Speech Therapy Note dated 01/30/23 at 4:36PM documented, "Patient seen for skilled dysphagia intervention during lunch ..." An admission minimum data set with an assessment date of 01/31/23 documented that the resident was coded for coughing or chokingduring meals or when swallowing medications and complaints of difficulty or pain with swallowing. Resident #255's care plan dated 02/01/23 documented, Focus Area- [Resident's name] has GERD (gastro-esophageal reflux disease) ...Interventions - monitor/document/report to MD (medical doctor) PRN (as needed) s/sx (signs/symptoms) of GERD: Belching, coughing/choking when lying down, heartburn, dyspepsia, N/V (Nausea/vomiting) indigestion, regurgitation, increased salivation, swallowing problems, bitter taste in mouth, dysphagia, substernal chest pain, increased gag response. A Speech Therapy Note dated 02/04/23 at 2:52 PM [Speech Therapy Note] documented, "Patientseen for skilled dysphagia intervention during lunch. Patient received mechanical soft lunch meal; however, most meal items more consistent	F 803		

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F 803	Continued From page 155 with regular texture (rice, chopped chicken, and beans). No sauce or gravy present on tray despite SLP (speech therapy) order on meal ticket. Patient requesting downgrade to puree texture ...SLP provided education to nursing ondowngrade and will follow up with kitchen management and dieticians ..." A physician order dated 02/04/23 documented, "Regular diet, pureed texture, thin consistency,extra sauce/gravy for all meals including breakfast to moisten food for dysphagia (swallowing difficulties)." In addition, on 2/6/23 the physician ordered the following: "Follow-up with GI (gastroenterologist)at [hospital's name] oropharyngeal dysphagia ..." A Speech Therapy Note signed on 02/16/23 at 7:47 AM, documented, "Patient seen for skilled ST (speech therapy) services targeting dysphagia ...nurse caregiverse (sp) reporting patient complaints of difficulty swallowing ...recommendfollow-up with GI (gastroenterologist) for further investigation ..." On 02/17/23 at approximately 8:40 AM, Resident #255 was observed sitting in a chair with a bedside table in front of him. The table had a covered breakfast tray on it. When asked, if he enjoyed his breakfast, he stated, "No, I can't eat it because it's not pureed." The resident allowed the surveyor to uncover the tray. The tray included one (1) uneaten hard-boiled egg, one (1)partially (approximately 10%) eaten biscuit, and one (1) carton of 2% white milk approximately 90% consumed. The resident was asked if he atethe biscuit, and he stated, "Yes, and I feel like it'sstuck in my throat. I've been drinking the milk to	F 803		

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F 803	Continued From page 156 push it down, But I still feel it." Review of the tray card that was on the tray documented the resident was to receive a "Regular Pureed" diet with "2xsmall cups sauce or gravy daily on the side". There was no gravy noted on the resident'smeal tray. Employee #2 (DON) was called to the bedside. She reviewed the tray card and said the residentshould not have received this diet because it is aregular texture and not pureed texture, as indicated on the tray card. Employee #16 (Dietician) was called to the bedside and asked ifthe meal the resident had in front of him was safefor him, and she stated, "This is not an appropriate diet for a pureed diet. He is being followed by speech therapy." During a face-to-face interview on 02/17/23 at 10:00 AM, Employee #12 (Speech Therapist Clinical Fellow) stated that the breakfast of a hardboiled egg and a biscuit served on 02/17/23was unsafe for the resident since the resident needed a pureed diet due to a dysphagia diagnosis. 1b. Review of Resident #255's physician orders revealed an order dated 02/04/23 that documented, "Regular diet, pureed texture, thin consistency, extra sauce/gravy for all meals including breakfast to moisten food for dysphagia(swallowing difficulties)." On 02/21/23 at approximately 8:45 AM, Resident #255 was observed eating breakfast. The texturewas pureed however the meal did not have gravy/sauce. Employee #3 (DON), Employee #11(Dietician), Employee #12 (Speech Therapist Clinical Fellow) were called to the resident's	F 803		

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F 803	Continued From page 157 room. They all reviewed the resident's diet order and stated that the resident was to be given gravyor sauce for all meals, including breakfast. However, Employee #13 (Dietary Director) statedthat her staff did not add gravy or sauce to Resident 255's breakfast because she thought the order for gravy/sauce on breakfast was an error. Based on these findings, on February 17, 2023, at 4:17 PM, an Immediate Jeopardy (IJ)-"J" situation was identified. On February 18, 2023, at2:21 AM, the facility's Clinical Executive Directorprovided a corrective action plan to the State Agency Survey Team, which was accepted. Theplan included: 1. Identification of Residents Affected or Likely tobe Affected: The facility took the following actions to address the citation and prevent any additionalresidents from suffering an adverse outcome. a. All residents that have pureed diets were assessed for any s/s of aspiration and for correctmeal consistency by the clinical leadership team.No other reports of residents receiving incorrect diet consistency. b. Administrator and Dietary Leadership team validated all lunch tray consistencies orderedwere accurate on meal trays. c. Education was initiated with all nursing and dietary staff in facility per SMS messaging to ensure that the meal tray tickets, and the residents' plates matched. Education will be validated for understanding by onsite educationon meal tray and residents' plates matching. (Completion Date: 2/20/23) 2. The Registered Dietitian or clinical leader personnel will conduct an audit to ensure all	F 803		

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F 803	Continued From page 158 dietary orders and recommendations are accurate in the medical record and match thedietary department's tray card information foreach resident per MD orders by 2/20/23. 3. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to preventan adverse outcome from reoccurring. (Completion Date: 2/23/23) -Meal tray distribution and practices and practices reviewed/revised. -Education was initiated with dietary and nursing staff by the Clinical Leadership and Dietary Manager/designee regarding applicable facility processes related to meal tray preparation (i.e.: meal ticket and plates match) and distribution, compliance with resident specific dietary interventions, and food preparation consistency with each residents' diet orders. Two nursing staffwill check trays prior to deliver to the residents inorder to ensure accuracy. -Activities will check PCC for diet order and consistency. Nursing staff ensure will that snackshave a label present that's includes resident name, diet, and consistency. -The Dietary Manager/designee and clinical management leaders will audit new admissions for 3 months to ensure the dietary orders/recommendations/ recommendations/documentation are accurate inthe medical record and match the dietary department's tray card information for that resident. -The Dietary Manager or designee will monitor food preparation at all three meals, and comparethe meal being prepared to the physician order/documentation for that resident's dietary needs. Monitoring/auditing will continue daily x 2weeks and weekly x 2 and then monthly x 3.	F 803		

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F 803	Continued From page 159 -The DON or designee will monitor food service at all three meals, and compare the meal being served to the physician order/documentation for that resident's dietary needs. Monitoring/ auditingdaily x 2 weeks and weekly x 2 and then monthlyx 3. -The Administrator or designee implemented a QAPI PIP as a means to gather and process information from the audits/monitoring processes.Findings will be reported at the monthly QAPI meeting for a minimum of 3 months. Date Facility Asserts Likelihood for Serious HarmNo Longer Exists: 2/18/23. The survey team verified implementation of theplan and lifted the immediate jeopardy on February 22, 2023, at 6:40 PM. Cross reference 22B DCMR sect. 3211.1(a)	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidencedby: Based on observation, record review, residentand staff interview for five (5) of 105 sampled residents, facility staff failed to provide food at appropriate temperatures for consumption, and	F 804		

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F 804	Continued From page 160 that met residents preferences (Residents #143,#251, #79, #197, and #231, The findings included: 1. Resident #143 was admitted to the facility on 11/21/2018 with multiple diagnoses that included: Cerebral Infarction, Muscle Weakness, Hypertension, Hyperlipidemia, Anemia and Gastro-Esophageal Reflux Disease. Review of Resident #143's medical record revealed a Care Plan dated 11/23/18 that documented "Interventions/Tasks - Update foodpreferences PRN (as needed)." Review of Resident #143's medical record revealed a Care Plan dated 03/13/19 that documented "Interventions/Tasks - Diet: Regular." A Quarterly Minimum Data Set (MDS) assessment dated 12/07/2022 documented Resident #143 had a Brief Interview for Mental Status score of "15" indicating the resident had an intact cognitive status and a Functional Statusfor Activities of Daily Living indicating Extensive Assistance for bed mobility, transfer, dressing, toilet use, personal hygiene. During a face-to-face interview with Resident #143 on 02/23/23 at 3:41 PM, the resident stated,"the food is horrible, I had suggested that they geta menu of different food items that the residents can choose from, but they told me they can't do that." During a face-to-face interview with Employee #11 on 03/06/2023 at 3:35 PM, the employee was	F 804	1.R231 was discharged from the facility on 04/25/2023. R143, R251, R79, and R197 currently reside in the facility with no ill effects noted. R143 was visited by the Registered Dietician on 3/17/23 to discuss her food preference and update the kitchen as needed. A 4- week menu cycle was provided to resident R143 on March 10, 2023, and resident expressed satisfaction. R251 IDT meeting was held on 3/8/23 in which resident’s food preference was updated. A follow-up was made with resident on 5/5/2023 and resident stated that food tastes better and it is hot enough to her liking. R79 food preferences and palatability were reviewed andupdated on 5/5/2023 to receive double portions and preferences updated. R197 was visited on 5/5/2023 and he verbalized that food is much better and that food is warm enough to his liking. Of Note: The “always available menu” was updated, and new	06/09/2023

updates will be made available on 05/09/2023.

2. The dietician or designee visited current residents in the facility to ensure that food provided to the residents are of appropriate temperature for consumption, and that meets the residents' preferences. All residents have the potential to be affected. Findings showed some meal trays not at appropriate temperature and preferences not met, which were corrected immediately.

3. The Nurse educator or designee will in service the nursing staff, registered dietician, and dietary staff to ensure that food provided to the residents are of appropriate temperature for consumption, and that meets the residents' preferences.

4. The dietician or designee will audit 10 % of the facility census to ensure that food provided to the residents are of appropriate temperature for consumption and based on preferences. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 6/09/23.

The Director of dietary services or designee will audit10% of the facility census to ensure that food provided to the residents are of appropriate temperature for consumption based on test trays. Director of dietary services or designee will audit 10% of the facility census to ensure that residents food preferences are followed per the meal ticket. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 6/09/23.

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F 804	Continued From page 161	F 804		

asked what processes are in place to ensure Resident #143 receives meals that are acceptable for her consumption and according toher preferences, Employee #11 responded, "Shecalls and updates me with her preferences and Iupdate her preferences. We told her we don't have a selective menu for her, but she can call me and I will put it on her ticket. Then it's reprinted to go to dietary immediately. This has been in effect for the past few months however, her preferences change regularly."

During the same interview, Employee #11 was asked what happens when the resident doesn't receive her preferences and the employee stated,"When they forget something on the resident's tray she calls me and I let the kitchen know. It doesn't happen often, but just happened last week. Then she calls me when she gets the item.She is very good at letting me know. I remember one time I brought it up myself because it's fasterthat way, but she changes her mind often ..."

2. Resident #251 was admitted to the facility on 08/09/2021 with multiple diagnoses that included: Blindness, Left Sided Hemiplegia and Hemiparesis Following Cerebral Infarction, End Stage Renal Disease-Dialysis Dependent, Type 2Diabetes and Hypertension.

Review of Resident #251's medical record revealed a Care Plan dated 08/09/21 that documented "[Resident #251] has an ADL (activities of daily living) self-care deficit needingassistance with ADL's ...Interventions/Tasks - Eating: [Resident #251] requires set up assistance by (1) staff to eat."

A Quarterly Minimum Data Set (MDS)

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F 804	Continued From page 162	F 804		

assessment dated 09/02/22 documented a Brief Interview for Mental Status score of "15" indicating the resident had an intact cognitive status and a Functional Status for Activities of Daily Living indicating Extensive Assistance for transfer, locomotion, dressing, toilet use, personal hygiene and supervision with eating.

Review of Resident #251's medical record revealed a Care Plan dated 12/22/22 that documented, "Focus - [Resident #251] at risk forimpaired nutrition r/t (related to) therapeutic diet
... Interventions/Tasks - Diet: NCS (no concentrated sweets), double portions
...Encourage adequate po intake ...Monitor mealintake
...Update food preferences PRN (as needed)."

During a face-to-face interview with Resident #251 at 1:36 PM, the resident stated, "The food isnasty. It's always cold at breakfast, lunch and dinner. When you ask them to warm up your food, they get an attitude like they don't want to help you. Every now and then the food is warm. The only time my food was hot was yesterday."

During a face-to-face interview with Employee #11 on 03/06/23 at 3:45 PM, the employee stated,"We don't have a selective menu for the residents; their preferences change regularly."

3. Resident #79 was admitted to the facility on 07/22/2021 with multiple diagnoses that included: Hyperlipidemia, Hypertension, Type 2 Diabetes, Morbid Obesity, Muscle Weakness, Pain in legs, Anemia and Adult Failure to Thrive.

Review of Resident #79's medical record revealed a Care Plan dated 07/26/21 that

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F 804	Continued From page 163 documented "[Resident #79] in need of therapeutic diet due to dx [diagnosis] DM [Diabetes Mellitus], HTN [Hypertension], obesity& high A1C [measurement of glucose (sugar) in the blood] ...Diet as ordered: NCS [no concentrated sweets]. Snack BID [twice a day].Assess need for snack/supplement as needed, updated food pref. [preference] as needed." A review of Resident #79's medical record revealed Registered Dietitian notes dated 9/6/22,9/7/22 and 12/6/22 that documented, "resident updated her meal dislikes." A Quarterly Minimum Data Set (MDS) assessment dated 12/07/22 revealed a Brief Interview for Mental Status score of "15" indicating the resident is cognitively intact and aFunctional Status for Activities of Daily Living indicating Total Dependence for transfer, locomotion on unit and toilet use. During a face-to-face interview on 02/23/23 at 3:41 PM, Resident #79 stated, "The food is not good. The portion is child size, but the portions are larger since ya'll been in the building. I don't like grilled cheese sandwiches. The food serviceis horrible. The food is not served hot, most times we have to ask to heat it up." During a face-to-face interview with Employee #11 (Registered Dietitian) on 03/06/2023 at 3:35 PM, the employee was asked what processes arein place to ensure Resident #79 receives meals that are acceptable for consumption and according to personal preferences, and Employee#11 stated, "We don't have a selective menu for residents. We update preferences and they change regularly."	F 804		

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F 804	Continued From page 164 4. Resident #197 was admitted to facility on 02/05/2020 with multiple diagnoses that included: Benign Prostatic Hyperplasia, Muscle Weakness, Hyperlipidemia, Vitamin D Deficiency, Anemia, Major Depressive Disorder and Unilateral Primary Osteoarthritis. A Quarterly Minimum Data Set (MDS) assessment dated 11/09/22 revealed a Brief Interview for Mental Status score of "15" indicating the resident is cognitively intact and aFunctional Status for Activities of Daily Living indicating Limited Assistance for Bed mobility, transfer, dressing and toilet use. During a face-to-face interview on 02/24/23 09:33AM, Resident #197 stated "the food is sometimescold when I get it." During a face-to-face interview with Employee #11 (Registered Dietitian) on 03/06/2023 at 3:35 PM, the employee was asked what processes arein place to ensure Resident #197 receives mealsthat are acceptable for consumption and according to personal preferences, Employee #11stated, "We don't have a selective menu for residents. We update preferences and they change regularly." 5. Resident #231 was admitted to the facility on 12/24/21 with multiple diagnoses that included: Vascular Dementia, Cognitive Communication Deficit, Muscle Weakness, End Stage Renal Disease, Malignant Neoplasm of Lung, Heart Failure, Cerebral Infarction, Dysphagia and Type2 Diabetes. Review of Resident #231's medical record	F 804		

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F 804	Continued From page 165 revealed a Care Plan dated 12/24/21 that documented "Focus - [Resident's name] has anADL (Activities of Daily Living) self-care deficit needing assistance with ADL's r/t (related to) history of stroke, seizures, vascular dementia, AMS (altered mental status) ... Intervention/Tasks - Eating: [Resident's name] is totally dependent on (1) staff for eating. (feeder)." Review of Resident #231's medical record revealed an Order Summary Report dated 12/24/21 that documented, "Liberal Renal dietRegular texture, No Concentrated Sweet." A 5-day minimum data set (MDS) assessment dated 12/20/22 documented Resident #231 had aBrief Interview for Mental Status score of "00" indicating the Resident had a severely impaired cognitive status and a documented Functional Status for Activities of Daily Living indicating (ADL) indicating Total Dependence of ADL care - Bed mobility, Transfer, Locomotion, Dressing, Eating, Toilet use and Personal hygiene. Review of Resident #231's medical record revealed a Dietitian Progress Note dated 02/17/22 that documented "Met with resident today, meal preferences updated.............................. Will follow up with resident as needed." Review of Resident #231's medical record revealed a Dietitian note dated 07/17/22 at 19:44(7:44 PM) that documented "Quarterly review: [Resident #231] consumes about 50-75% average Liberal Renal NCS (no concentrated sweets) diet supplemented with Nepro 1 can BID(twice a day)." Review of Resident #231's medical record	F 804		

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F 804	Continued From page 166 revealed Order Summary Report dated: -11/28/22 documenting, "Prosource one time aday 60 ml (milliliter) for protein supplement." -12/14/22 documenting, "Nepro three times a dayDiet supplement due to poor PO (oral) intake andweight loss; Liberal Renal diet Pureed texture, Nectar Thick consistency, No Concentrated Sweet; and Multivitamin Tablet (Multiple Vitamin)Give 1 tablet by mouth one time a day for supplement." -12/15/22 documenting, "ST (speech therapy): patient downgraded to puree/nectar thick liquidfor safety concerns ... the following swallow strategies are recommended: slow rate, small bites/sips, upright positioning, intermittent liquidwash." -12/30/22 documenting, "Aspiration Precaution every shift." During a face-to-face interview with Resident #231's responsible party on 02/22/23 at 4:54 PM,he/she stated, "She doesn't like pureed food. Shewas recently switched from chopped food because [the facility's staff] said she had a swallowing issue, but she eats the food we bring.We just chop it up and make sure she is sitting up in bed and she eats really good. I also think the taste of the food she does not like, but definitely not Pureed because she don't like the consistency." Review of Resident #231's medical record revealed a History and Physical Assessment dated 02/24/23 at 9:15 AM that documented "[Pronoun] did not answer questions today-just	F 804		

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F 804	Continued From page 167 looked at me. This is baseline, where sometimes [Resident #231] respond and other times not. Staff report that [Resident #231] is eating well. Asked for food the last time I saw her." During a face-to-face interview with Employee #11 (Registered Dietitian) on 03/06/2023 at 3:35 PM, the employee was asked what processes arein place to ensure residents receive meals that are acceptable for consumption and according topersonal preferences. Employee #11 stated, "Wedon't have a selective menu for residents. We update the resident's preferences." Cross Reference 22B DCMR sect. 3220.2, 3219.1, and 3220.3	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,state or local authorities. (i) This may include food items obtained directlyfrom local producers, subject to applicable Stateand local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicablesafe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute andserve food in accordance with professional standards for food service safety.	F 812		

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F 812	Continued From page 168 This REQUIREMENT is not met as evidencedby: Based on observations and staff interview, facilitystaff failed to distribute and serve foods under sanitary conditions as evidenced by foods such as puree Salisbury Steak, puree peas, and from the regular menu, mashed potatoes that tested below 135 degrees Fahrenheit (F). The findings include: Lunch food temperatures were inadequate and failed to test at 135 degrees Fahrenheit (F) or more during a food tray test on January 4, 2023,at approximately 1:00 PM, on three (3) of five (5)observations. Pureed menu Salisbury steak tested at 133.3 degrees Fahrenheit (F), and pureed peas testedat 131.3 degrees. Regular menu Salisbury steak tested at 135 degrees F, Mashed potatoes tested at 134 degrees F and peas tested at 137.8°F. Employee #7 acknowledged the findings on February 21, 2023, at approximately 1:45 PM	F 812	1. No resident suffered ill effects. Tray warmers ordered and currently in use. One Oven in useand 3 on order expected to be shipped on 05/09/2023 as per Director of dietary service. 2. The Director of dietary service or designee will review the hot food temperatures being distributed and servedto residents to ensure it is done under sanitary conditions by making sure that thetemperature is at least 135 degrees Fahrenheit or greater. Findings showed that 135 degrees or greater was achieved. All residents have the potential to be effected. 3. The Nurse educator or designee will in service the dietary staff to ensure that the hot foods temperatures being distributed and served to residents are done under sanitary conditions by making sure that thetemperature is at least 135 degrees Fahrenheit or greater. 4. The Director of dietary service or designee will audit 10% of the food carts by testing the temperature of the last food tray to ensure that hot foods temperatures beingdistributed and served to residents are doneunder sanitary conditions by making sure that the temperature is at least 135 degreesFahrenheit or greater. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	06/09/2023
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agentagrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		

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F 842	Continued From page 169to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facilitymust maintain medical records on each residentthat are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliancewith 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to averta serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retainedfor- (i) The period of time required by State law; or	F 842	1.R492 was discharged from the facility on 11/17/2022. R132, R93, R101, and R313 currently reside in the facility with no ill effects noted. R313. Weights documented on 3/7/23. She has had no significant change in weight since that time. An educational session was heldon 4/19/23 to 4/20/23 for licensed professional nurses to ensure that alteration in skin integrity were documented upon admission/readmission Licensed nurses' education initiated on 5/6/2023 to ensure blood pressure readings are accurately documented on R93 as being obtained onthe right arm due to AV fistula present on left arm. R101. Licensed nurses' education initiated on 5/6/2023 to ensure that behaviors documentedin progress notes are reflected in the TAR. 2.The Director of nursing or designee will review the current resident in the facility census for the past 7 days to ensure that	06/09/2023

resident's records contain accurate documentation by making sure that nutritional summary intake is documented to completion, that skin integrity issues identified on admission/readmission are documented in admission screener, that dialysis residents access site is clearly identified to assure that site for blood pressure was accurately documented, andthat behaviors documented in progress notes is reflected in the TAR. Data is still being collected and tabulated for these areas.

3. The Nurse educator or designee will educate nursing staff on obtaining and documenting weights based on protocol.
The Nurse educator or designee will in service the licensed professional nurses toensure that residents records contain accurate documentation by making sure that nutritional summary intake are documented to completion, that skin integrity issues identified on admission/readmission are documented in admission screener that site where blood pressure was obtained is accurately documented for dialysis residents with access site , and that behaviors documented in progress notes is reflected in the TAR .

4. The Director of nursing or designee will audit 10 % of the facility census to ensure that residents records contain accurate documentation related to weights and nutritional summary intake form completion, skin integrity issues identified on admission/readmission are documented in admission screener, that site where blood pressure was obtained is accurately documented for dialysis residents based on access site, and that behaviors documented in progress notes is reflected in the medical record. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23

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(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reacheslegal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screeningand resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidencedby:
Based on observations, record reviews, resident interview, and staff interviews for six (6) of 104 sampled residents, the facility's staff failed to ensure resident's records contained accurate documentation. (Residents #132, #93, #101, #313, and #492.)

The findings included:

1. The facility's staff failed to ensure Resident #313's "Nutritional Intake Summary" forms dated02/07/23 to 02/09/23 accurately documented foods consumed or not consumed by the resident.

Resident #313 was admitted to the facility with multiple diagnoses including: Dementia, Parkinson, Stage 4 Sacral Pressure Ulcer, and Anxiety.

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F 842	Continued From page 171 A review of the resident's medical record revealeda nurse practitioner's progress note dated 02/06/23 at 1:36 PM that documented, "Was asked to see pt (patient) for slight wt (weight loss), poor po intake. She does not open her mouth at times and sometimes holds food in mouth ... Plan ...obtain a 3 day food diary ...will evaluate after food diary review. Will discuss withfamily regarding PEG if po (by mouth) intake not sufficient meet nutritional needs." It should be noted that review of the resident's "Weights and Vital Summary" sheet lacked documented evidence staff weighted Resident #313 from 12/21/22 to 03/02/23. A physician order dated 02/06/23 instructed "Food Diary X (times) 3 days for weight loss." A review of a document titled, "Nutritional Intake Summary" dated from 02/07/23 to 02/09/23 revealed the lunch section for 02/07/23 and 02/08/23 was incomplete. The 02/07/23 the facility failed to document the resident's intake ofmeat, starch, bread/roll, vegetable, dessert and other. On 02/08/23 the facility's staff failed to documentthe resident's intake of milk, meat, starch, bread/roll, vegetable, dessert and other. During a face-to-face interview on 03/06/23 at approximately 10:14 AM, Employee #11 (Dietician) reviewed the Nutritional Intake Summary dated from 02/07/23 to 02/09/23 andstated that the documented was not accurate orcomplete because staff did not document the resident's intake in all sections of the form. Employee #11 then said that if the resident did not eat foods listed in the individual section staff	F 842		

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F 842	Continued From page 172 were to document "0%". During a face-to-face interview on 03/06/23 at approximately 12:45 PM, Employee #39 (Nurse Practitioner) stated that she started the 3-day food log because staff informed that the residenthad a poor intake with meals. After reviewing thefood log, the employee said the log was not accurate or complete because the staff did not complete all sections. 2. The facility's staff failed to ensure Resident #132's "Admission/Re-Admission Screener" dated 01/08/23 contained accurate informationrelated to the resident's skin integrity status. Resident #132 was admitted to the facility on 01/08/23 with multiple diagnoses including Malignant Pancreas and Aftercare Following Surgery on Digestive System. A review of a titled, "Admission/Re-admission Screener" dated 01/08/23 at 10:29 PM lacked documented evidence of the resident's surgical wound. A review of a history and physical dated 01/10/23at 4:00 PM, documented, "[Resident #132] presented to [hospital's name] ... diagnosed withPancreatic Adenocarcinoma ... s/p (status-post) laparoscopic pancreatectomy and splenectomy and liver biopsy on 12/15/22 ...skin warm, dry, surgical incision line extends from just below xiphoid process to just above umbilicus - sterri strips intact " A review of the resident's admission Minimum Data Set dated 01/15/23, documented Resident#132's had a Brief Interview of Mental Status	F 842		

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summary score of "8" indicating the resident hada moderately impaired cognitive status. In addition, the resident was coded for having a surgical wound.

During an observation on 02/13/23 at approximately 1:00 PM, Resident #132 was observed in his room lying in bed reading a bible.The resident stated that he was waiting for the nurse to bring his cancer medication (Megace). The resident said he had his pancreas, spleen and part of his liver removed before being admitted to the facility. The resident admitted hehad a surgical wound on admission, but the wound was healed at this time.

During a face-to-face interview on 02/13/23 at approximately 2:00 PM, Employee #24 (RN/2 North's Unit Manager) stated that the nurse should have documented Resident #132's surgical wound.

3. The facility's staff failed to ensure Resident #93, who had a left arm dialysis AV fistula, had accurate blood pressure access sites documented on her "Blood Pressure Summary"sheet from 02/02/23 to 02/27/23.

Review of Resident #93's medical record showedthat the Resident was admitted to the facility on 06/27/17 with diagnoses that included: End StageRenal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, and Generalized Muscle Weakness.

Review of a Physician Orders dated 03/22/19 directed:

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F 842	Continued From page 174 "Monitor dialysis access site on left upper arm forsigns and symptoms of infection every shift." "Check dialysis access site q (every) shift for positive bruit and thrill on left upper arm AV graft every shift." Review of the facility ' s "Hemodialysis" policy, implemented on 02/01/22, stated: "Compliance Guidance ...The Resident will not receive blood pressure or laboratory sticks on the arm wherethe dialysis access device is located................. " Review of the Resident's medical record revealeda Quarterly Minimum Data Set Assessment dated 12/25/22 that documented a Brief Interview for Mental Status (BIMS) summary score of "14", indicating that the Resident had intact cognition and was on dialysis. Review of Resident #93's Blood Pressure Summary for February 2023 showed the following: 02/02/23 12:11 PM 127/76 mmHg (Lyingl-left/arm) 02/02/23 5:29 PM 128/72 mmHg (Sitting l/arm) 02/02/23 11:14 PM 132/67 mmHg (Lying l/arm) 02/03/23 7:11 PM 128/73 mmHg (Sitting l/arm) 02/05/23 4:19 PM 136/70 mmHg (Sitting l/arm) 02/05/23 8:00 PM 133/66 mmHg (Sitting l/arm) 02/06/23 8:21 PM 137/76 mmHg (Sitting l/arm) 02/07/23 9:03 PM 127/74 mmHg (Sitting l/arm) 02/08/23 9:36 PM 132/74 mmHg (Sitting l/arm) 02/09/23 11:57 PM 137/78 mmHg (Lying l/arm) 02/12/23 11:15 PM 132/74 mmHg (Sitting l/arm) 02/14/23 11:34 PM 127/74 mmHg (Sitting l/arm) 02/16/23 12:51 PM 128/72 mmHg (Sitting l/arm) 02/16/23 9:51 PM 127/74 mmHg (Sitting l/arm) 02/17/23 8:03 PM 137/72 mmHg (Sitting l/arm) 02/18/23 8:00 PM 128/70 mmHg (Sitting l/arm)	F 842		

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F 842	Continued From page 175 02/19/23 11:16 AM 135/70 mmHg (Sitting l/arm) 02/20/23 10:20 PM 129/76 mmHg (Sitting l/arm) 02/21/23 5:54 PM 127/72 mmHg (Sitting l/arm) 02/22/23 11:42 PM 123/72 mmHg (Sitting l/arm) 02/23/23 11:23 AM 126/74 mmHg (Sitting l/arm) 02/23/23 11:15 PM 124/76 mmHg (Sitting l/arm) 02/25/23 7:56 PM 128/76 mmHg (Lying l/arm) 02/25/23 5:54 PM 127/72 mmHg (Sitting l/arm) 02/27/23 7:04 PM 169/66 mmHg (Sitting l/arm) According to the Resident ' s Blood Pressure Summary for February 2023, facility staff documented that they took blood pressure in Resident #93's left arm (the dialysis access arm) twenty-five (25) times. During an observation on 03/01/23 at 11:00 AM Resident #93 was observed sitting in her wheelchair in her room. The resident had a drybandage wrapped around her upper left arm. During a face-to-face interview on 03/01/23 at 11:00 AM with Resident #93, when asked which arm facility staff used to measure blood pressure, the Resident stated, "They always use the right arm. I make sure they do. I've had this site for a long time and don't want anything to happen to it." During a face-to-face interview on 03/21/23 at 11:05 AM, Employee #23 (1 South Unit Manager)reviewed the Resident's Blood Pressure Summary Report and stated, "It is mainly the night shift. I am sure they are taking the blood pressure in the correct arm but are documenting it incorrectly ..." The Employee then acknowledged the finding and made no further comment. 4. The facility staff failed to ensure that	F 842		

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F 842	Continued From page 176 documentation contained in the treatment administration record accurately documented Resident #101's altercation and behavioral outbursts that were documented in the progressnotes. Resident #101 was admitted to the facility on 01/29/2016, with multiple diagnoses that included the following: Dementia with Behavioral Disturbance, Alcohol Abuse with Intoxication, andOther Reduced Mobility. [Behavior Note] 07/06/22 at 3:01 PM, "[Resident #101] was heard yelling and screaming loud, verbally aggressive towards charge nurse, he stood up from his wheelchair close to the nursingstation and attempted to swung (sp) to the chargenurse and keep saying and yelling ...he continue(ed) (sp) to be verbally aggressive and keep swinging on the air ...DNP was in house andshe witnessed [Resident #101] behavior and order to give Ativan (anti-anxiety) 2 mg (milligrams)/ml (milliliters) X (times) 1 dose " A review of the "Treatment Administration Record" dated 07/06/22 in the section titled "Monitor for any behaviors Resident is prescribedpsychotropic medications every shift" showed thatthe facility staff documented "No" for the day evening and night shifts. A review of the "Treatment Administration Record" dated 07/06/22 in the section titled "Monitor for: Specify behaviors verbally abusive" showed that the facility staff documented "No" forthe day, evening and night shift. [Nursing Progress Note] 07/12/22 at 4:16 PM, " ... [Resident #101] was involved in physical	F 842		

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altercation with other resident ...in the first floor near the elevator. [Resident #101] was asked what happened he stated that he was passing byin the first-floor hallway near the elevator when heheard that [Resident #121] said something he don't like it, he added that he smack the (...) out of him ...Assessment was done, smell of alcohol was noted when he was talking ..."

A review of the "Treatment Administration Record" dated 07/12/22 in the section titled "Monitor for any behaviors Resident is prescribedpsychotropic medications every shift" showed thatthe facility staff documented "No" for the day evening and night shifts.

A review of the "Treatment Administration Record" dated 07/12/22 in the section titled "Monitor for: Specify behaviors verbally abusive" showed that the facility staff documented "No" forthe day, evening, and night shifts.

A review of the Quarterly Minimum Data Set (MDS) dated 02/08/23 revealed that the facility staff coded that a Brief Interview for Mental statusshould not be conducted and that the resident has both a short-term and long-term memory problem

During a face-to-face interview conducted on 03/06/23 at 12:43 PM, Employee #18 (Unit Manager 3 South) stated that staff should have documented the behaviors in the Treatment Administration Record.

5. Facility staff failed to accurately document Resident #492's Annual Minimum Data set (MDS)dated 07/07/22 as evidenced by staff documenting the resident as being on a

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prescribed weight loss regimen when there wereno orders for a weight loss dietary regimen.

Resident #492 was admitted to the facility on 08/07/20 with multiple diagnoses that included thefollowing: Malignant Neoplasm of the Right Female Breast, Abscess of the Breast and Nipple, Cerebral Infarction, Dysphagia Following Cerebral Infarction, and Heart Failure.

A review of the Annual Minimum Data Set (MDS) dated 07/07/22 revealed that the facility staff coded the resident as the resident's height was coded as 63 inches and weight as 133 lbs. The facility staff coded the resident as having weightloss of 5% or more in the last month or 10% or more in the last 6 months and that the resident was on a physician-prescribed weight-loss regimen.

A review of a Complaint submitted by the Residents responsible party to the State Agency on 07/14/22, documented " ..."My mother is verythin and frail, she was 230 pounds when she firstarrived in 2020. She doesn't appear to be clean.Her hair looks like a nest for birds. her soap is missing, her shampoo has not been used.
Testimony from her roommate that she does notget snacks and goes hungry. My mother stated that a CNA took her egg and she was saving thatbecause she is not get her snacks. She has an abscess on her chest that is not healing ..."

The medical record lacks any documented evidence of physician's orders for a weight lossprogram.

During a face-to-face interview conducted on 03/10/23 at approximately 2:30 PM, Employee

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F 842	Continued From page 179 #18 (Unit Manager 3 South) stated that the resident lost significant weight while in the facilityand acknowledged the findings. 6. Facility staff failed to maintain medical recordsthat were accurate and in accordance with accepted professional standards as evidenced bythe facility staff creating care plans for Resident #492 one month after the resident was deceased. Resident #492 was admitted to the facility on 08/07/20 with multiple diagnoses that included thefollowing: Malignant Neoplasm of the Right Female Breast, Abscess of the Breast and Nipple, Cerebral Infarction, Dysphagia Following Cerebral Infarction, and Heart Failure. A review of the Annual Minimum Data Set (MDS) dated 07/07/22 revealed that the facility staff coded the resident as having moderate cognitiveimpairment. Resident #492's medical record revealed the following: [Nurse's Progress Note] 11/17/22 " ...(Resident #492) is unresponsive. During assessment unable to respond to verbal command ...911 staffterminated CPR (cardiopulmonary resuscitation)since (resident #492) is asystole and irreversible.Dr. (...) pronounce the time of death at 2:45 Pm,...Post-mortem care was given ..." [Care Plan] initiated on 12/14/22 focus- "(Resident #492) at nutritional risk r/t (related to) slightly low BMI for age and altered skin integrity." Interventions initiated on 12/14/22 " ...Diet Regular, snack BID (twice daily), Encourage	F 842		

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F 842	Continued From page 180 adequate PO (by mouth) intake and hydration, MD (medical doctor)/NP (nurse practitioner) to assess as needed medication as ordered, Medpass as ordered, monitor wts (sp) (weights),labs, skin status, and meal intake ..." [Care Plan] initiated on 12/14/22, Focus- "(Resident #492) has potential impairment to skinintegrity r/t (related to) decreased mobility." Interventions initiated on 12/14/22 " ...Educate (Resident #492)/ family/caregivers of causative factors and measures to prevent skin injury. Elevate heels off bed, encourage good nutritionand hydration in order to promote healthier skin ..." It is noted that the above-mentioned care planswere initiated by the facility staff 27 days after Resident #492 was deceased. During a face-to-face interview conducted on 03/10/23 at approximately 2:30 PM, Employee #18 (Unit Manager 3 South) stated that Resident#492 passed away in the facility on 11/17/22 andgave no explanation as to why the care plans were initiated on 12/14/22. Cross Reference 22B DCMR sect. 3231.11	F 842		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part ofa multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the	F 865		

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F 865	Continued From page 181 outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development,implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the StateSurvey Agency no later than 1 year after the promulgation of this regulation. §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon requestduring any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance withrequirements to a State Survey Agency, Federalsurveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the fullrange of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices;	F 865	1. No ill effects were noted to residents at this time. A QAPI plan was developed on 05/11/2023 To ensure that the resident environments have safe/clean/comfortable/homelike environment. A QAPI plan was developed on 05/11/2023 to ensure that residentsare free from abuse, neglect, and exploitation. A QAPI plan was initiated on 01/01/2022 and for treatment/services to prevent/heal pressure ulcers. A QAPI plan was initiated on 01/01/2023 to ensure that residentsare free from accident hazards/supervision/devices and revised 05/11/2023. A QAPI plan was developed on 05/11/2023 to ensure that residentsare free from significant medicationerror. 2. The Director of quality improvement or designee will review the QAPI plan submitted of all areas identified to assess whether that improvement plan had corrective and preventative actions in placeto prevent further deficient practice for - safe/clean/comfortable/homelike	06/09/2023

environment.
- residents are free from abuse, neglect,and exploitation.
- treatment/services in place to prevent/heal pressure ulcers
-residents are free from accident hazards/supervision/devices
residents are free from significant medication errors.
Findings indicated that all QAPI plans are in place and provide interventions that promote sustained compliance.
All residents have the potential to be affected.

3.The Director of environmental services or designee will in service the environmental service staff regarding the QAPI plan to ensure that the residents' environment is safe/clean/comfortable/homelike environment.

The Director of nursing or designee will in-service all staff regarding the QAPI plan to ensure that residents are free from abuse, neglect, and exploitation.

The Director of nursing or designee will in-service the Licensed nursing staff regardingthe QAPI plan to ensure that there is a treatment/services to prevent/heal pressure ulcers.

The Educator or designee will in-service the facility staff regarding the QAPI plan to ensure that residents are free from accident hazards/supervision/devices.

The Educator or designee will in-service nursing staff regarding the QAPI plan to ensure that residents are free from significant medication error.

4. The Director of quality improvement or designee will review audits completed to assure that corrective actions demonstrate sustained compliance of areas identified: residents' environment is safe/clean/comfortable/homelike environment, that residents are free from abuse, neglect,and exploitation, there is a treatment/services to prevent/heal pressureulcers, that residents are free from accidenthazards/supervision/devices,

that residentsare free from significant medication errors.
Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 6/09/23

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F 865	Continued From page 182 §483.75(b)(2) Include clinical care, quality of life,and resident choice; §483.75(b)(3) Utilize the best available evidenceto define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of aSNF or NF. §483.75(b) (4) Reflect the complexities, uniquecare, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership(or organized group or individual who assumes full legal authority and responsibility for operationof the facility) is responsible and accountable forensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustainedduring transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.	F 865		

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F 865	Continued From page 183 §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set aroundsafety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related tothe compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used asa basis for sanctions. This REQUIREMENT is not met as evidencedby: Based on staff interview, the facility failed to maintain and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems as evidenced by failure toidentify areas for improvement and to develop and implement corrective and preventive actions.The resident census during the survey was 343. The findings included: Facility staff failed to identify areas for improvement and to develop and implement corrective and preventive actions for the deficiencies as follows: Under§483.10, F 584 Safe/clean/comfortable/ Homelike Environment Under §483.12, F600 Freedom from Abuse, Neglect, and Exploitation	F 865		

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F 865	Continued From page 184 Under §483.25(b)(1) F686Treatment/Services to Prevent/Heal Pressure Ulcers Under §483.25(d)(2), F689 Free of Accident Hazards/ Supervision/Devices Under §483.45 F 760 Residents Free of Significant Med Errors On 3/10/23 at approximately 2:30 PM, a face-to-face interview was conducted with Employee #5 (Director of Quality Improvement) regarding Quality Assurance and Performance Improvement (QAPI). Employee #5 stated, "The committee met every month except March, April, May, June, and July in 2022. Since 2023, the QAPI committee has met in January and February. All department heads and some directcare staff participate." At the time of the Quality Assessment and Assurance (QAA) interview. Employee #5 was asked if the facility identified environment services (facility cleanness), resident-to-residentabuse and altercations, resident behaviors, pressure ulcers, supervision and monitoring, andmedication errors as concerns. Employee #5 reported, the facility was aware that the facility was not as clean as it should be, we that there were leaders on each unit to ensure its clean. Regarding resident-to-resident altercations, Employee #5 stated the facility keeps residents apart, transfer residents to different units, ensures that the smoking patio is monitored, educates residents to speak with staff not take matters into their own hands, and involves psychfor a medication alteration. For pressure ulcers, Employee #5 reported thatthey are looked at monthly on Fridays and they	F 865		

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F 865	Continued From page 185 talk to the wound nurse. They report out the number of wounds each month and [agency name] comes in to do a head-to-toe assessmentand create a plan. Employee #5 stated medications are looked at often and are in the electronic medication administration record (E-MAR) and that medications are available. The employee also stated the Pharmacy comes to look at the medication carts. In addition, it was reported that medications are given based on the presenter. It was also noted during the QAPI review that there was a monthly audit for food textures andmenus to ensure residents receive appropriatediet. Through an interview with Employee #5 at the time of the QAPI review, it was determined that the Quality Assurance committee/facility staff failed to identify areas for improvement, developand implement corrective and preventive actions.Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 865		
F 880 SS=E	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent thedevelopment and transmission of communicablediseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection preventionand control program (IPCP) that must include, at	F 880		

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F 880	Continued From page 186 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautionsto be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organisminvolved, and (B) A requirement that the isolation should be theleast restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followedby staff involved in direct resident contact.	F 880	1.R75 was discharged from the facility on 04/28/2023. R587, R76, and R313 currently reside in the facility with no ill effect noted. R587 was assessed on 3/11/23 by charge nurse with no issues noted, R76 was assessed on 3/9/23 by Nurse practitioner, R313 was assessed on 3/14/23 by Nurse practitioner with no issues noted. Wound nurses were in-serviced on 5/31/2023and by Wound manager who was in turn in-serviced by Wound NP on performing proper hand hygiene and on maintaining infection control andprevention practices during wound care, dressing changes. Wound nurses currently in-service on how to replace stool contaminated incontinent pad with a clean field prior to assisting with wound care. Licensed nurses' education was provided to ensure PICC line dressings are changed weekly Licensed nurses were educated notto punch medication in the palm of ungloved hands, but rather directly into a medication cup. Environmental services was educated on the importance of monitoring on appropriate disposals of PPEs such as gloves, mask, face shields in appropriate receptacles in the parking lot and receptacles not being over full	06/09/2023

2.The Infection Preventionist / designee conducted observational rounds of staff to ensure that staff maintain infection control and prevention practices during wound care, dressing changes and medication administration.

Environmental services director or designee conducted observational rounds of the parking lot to monitor the appropriate disposals of PPEs such as gloves, mask, face shields in receptacles and that receptacles are not full.

The Infection Preventionist / designee reviewed current residents with PICC lines toassure that dressings were changed weekly.
Findings showed no deviation from standard of practice.
All residents with PICC lines have the potential to be effected.

3.The Regional clinical consultant or designee will in service the nursing staffto ensure that staff maintain infection control and prevention practices during wound care, dressing changes and medication administration. The Regional clinical consultant or designee will educate licensed nursing staff to assure that residents with PICC line should have PICC dressings changed weekly.

Environmental services director or designee will in service the environmental service staff to monitor the parking lot in order to assure appropriate disposals of PPEs such as gloves, face mask, face shields in receptacles and that receptacles are not full

4.The Infection Preventionist or designee will conduct observational rounds of staff to ensure that staff maintain infection control and prevention practices during wound care, dressing changes and medication administration. Infection Preventionist /designee will audit PICC dressings to assure that it is changed weekly.

Environmental service director or designee will do observational rounds of parking lot to assure appropriate disposals of PPEs such as gloves, face mask, face shields in receptacles and that receptacles are not full.

Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 6/09/23

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§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.This REQUIREMENT is not met as evidencedby:
Based on record review and staff interview, for four (4) of 105 sampled residents, the facility's staff failed to maintain Infection Control and Prevention Practices during wound care, dressingchanges, and medication administration. (Residents #587, #76, #75, and #313. In addition,the facility failed to ensure trash and used personal protective equipment was disposed of properly.

The findings include:

1. Resident #587 was admitted to the facility on 02/07/23 with multiple diagnoses including: Third Degree Burns of Trunk and Surgical Aftercare following Surgery on the Skin.

A review of a care plan dated 02/08/23 documented, "Focus area- Actual skin impairment r/t (related to) second and third degree burn to bilateral lower extremities (Left/right). The care plan listed several interventions including monitor for s/s (signs and symptoms) of infections ...treatment as the

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affected side as ordered ..."

A review of a physician order dated 02/09/23 documented, "Aquaphor Advanced Therapy External Ointment ... cleanse wound with soap and water, pat dry, apply Aquaphor ointment andleave to air ..."

A review of a physician order dated 02/09/23 documented, "Aquaphor Advanced Therapy External Ointment (Emollient) apply to scrotum topically every day and evening shift for wound care.

A review of an admission Minimum Data Set dated 02/14/23 revealed the resident had a Brief Interview for Mental Status summary score of "14" indicating the resident had an intact cognitivestatus. The resident was also coded for having surgical wounds and second or third-degree burns.

During an observation on 03/07/23 starting at approximately 11:00 AM, Employee #55 provided wound care for Resident #587's as follows:

-The resident was observed lying in bed on top ofa blood-stained gown.

-Employee #55 (LPN-wound care nurse) cleanedthe bedside table and set-up wound care supplies.

-She used hand sanitizer and put on gloves.

-The employee cleansed and pat dry multiple closed and open wounds on the resident's thighs.

-She removed her gloves but failed to perform

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hand hygiene before opening a drawer in the resident's nightstand.

-The employee removed a container of Aquaphor Advanced Therapy External Ointment from the drawer.

-After removing the container, she placed it on the bedside side table, and put on a new pair of gloves. Again, she failed to perform hand-hygienebefore putting on a new pair of gloves.

-She used her gloved hands to scoop the ointment from the container and applied the ointment to the resident's wounds both open andclosed.

When applying the ointment to the resident's wounds, the employee failed to use a clean applicator such as a q-tip, clean tongue blade, orclean 4X4. Instead, she used her gloved hands toapply the ointment.

In addition, she failed to change her gloves in-between applying ointment to the open wounds (cross-contaminated)

During the observation, Resident #587 stated tothe surveyor, "I see you writing everything down.Don't tell her [Employee #55] she's doing a bad job. She's doing a good job with my wounds."

During a face-to-face interview on 03/07/23 at approximately 11:45 AM, Employee #55 stated that she should not have performed wound carewhile the resident laid on top of a blood-stained gown, she should have performed hand hygienebetween gloves changes, and to avoid touchingthe resident's wound, she should have used an

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F 880	Continued From page 190 applicator to apply the ointment to the wounds. The employee was asked how she ensures the ointment is cleaned if the resident uses it at the bedside. She said that she would get a containerof ointment for the wound cart, so she won't haveto use the ointment that's at the bedside. 2. Resident #313 was admitted on 11/11/22 with multiple diagnoses including Stage 4 Sacral Pressure. A review of care plan dated 11/11/22 documented, "Focus area- [Resident's name] haspotential/actual impairment to skin integrity r/t (related to) multiple wounds. Interventions- followfacility protocols for treatment for treatment of injury ..." A review of a nursing progress note dated 11/12/22 at 3:28 PM, documented, "Focus newadmit skin re-check assessment ... Resident observed with sacrum wound ...see physician orders for details ..." A review of a physician order dated 11/12/22 instructed, "Sacral wound cleanse with Dakin's Solutions, apply wet to dry dressing gauze, coverwith dry dressing every day. An observation on 03/07/23 starting at approximately 10:50 AM, showed Employee #48performed the following actions: -Gathered supplies at the bedside to providesacral wound care. -Performed hand hygiene. -Put on gloves. -Assisted Employee#49 (CNA) with repositioning	F 880		

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F 880	Continued From page 191 the resident to the right side. -Used the incontinent pad to remove stool from the resident's buttocks. -Wrapped the stool in the incontinent pad andtucked it under the resident. -Removed dirty gloves, performed hand hygiene,put on clean gloves. The employee failed to replace the stool contaminated incontinent pad with a clean field before performing wound care. A review of a minimum data set assessment dated 02/18/23, documented the resident had a Brief Interview Mental Status summary score of "99" indicating the resident was unable to complete the interview. The resident was also coded for requiring extensive assistance from twostaff members for bed mobility, always having urinary and bowel incontinence, and having one unhealed stage 4 pressure ulcer. During a face-to-face interview on 03/07/23 at approximately 11:20 AM, Employee #48 statedthat the stool-contaminated incontinent pad wasnot replaced because the stool was covered bythe pad and tucked under the resident. She considered that a clean field. During a face-to-face interview on 03/08/22 at approximately 3:00 PM, Employee #3 (Director of Nursing; DON) stated that Employee #48 shouldhave removed the contaminated pad and replaced it with a clean field before providing wound care. 3. Resident was admitted to the facility on 12/19/18. The resident had a history of multiple diagnoses including Sepsis, Local Skin Infections,	F 880		

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F 880	Continued From page 192 Stage 3 Pressure Ulcer and Stage 4 PressureUlcer. An observation on 02/21/23 at 1:10 PM revealed Resident #75 lying in bed with a PICC line in the right upper arm. The dressing on the PICC line was dated 01/09/23. At the time of the observation Employee #24 (Unit Manager/RN) stated that nursing staff were to change the resident's PICC line dressings weekly. She couldnot explain why the PICC line dressing had not been changed from 01/09/23 to 02/21/23. A review of progress notes, Medication Administration Records, and Treatment Administration Records lacked documented evidence facility's staff changed Resident #75'sPICC line dressing from 01/09/23 to 02/21/23. A review of a physician order dated 02/21/23 documented, "D/C (discontinue) PICC Line ..." 4. Resident #76 was admitted to the facility on 09/19/22 with multiple diagnoses including hypertension. A review of a physician order dated 09/20/22 instructed, "Carvedilol tablet 6.25 MG (milligrams) -give 1 tablet by mouth two times a day for HTN (hypertension) ..." During an observation on 03/03/23 at approximately 8:30 AM, Employee #48 was observed in the hallway standing at the medication cart putting a white tablet in a clearmedication cup. The employee punched the medication in the palm of ungloved hand. Theemployee was asked she was doing, and shestated that she was preparing Resident #76's	F 880		

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F 880	Continued From page 193 medication for administration. When asked, whydid she put the resident's medication in the palmof her hand before putting it in the medication cup, she stated, 'I didn't realize I did that." The surveyor instructed the employee to discard thetablet and start over. During a face-to-face interview on 03/03/23 at approximately 9:00 AM, Employee #3 (Director of Nursing; DON) stated that the employee should not have touched the resident's medication with her bare hands. The employee said she'll providethe employee education on Infection Control during Medication Pass. Cross reference 22B DCMR sect. 3217.1 5. Observations from February 21, 2023 - March10, 2023, revealed -trash such as used gloves, used face masks, and used face shields, scattered throughout thefacility parking; and -one (1) of two (2) trash receptacles located in the facility parking lot was excessively filled on numerous occasions. These findings were acknowledged by Employee#3 on March 10, 2023, at approximately 8:00 PM.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,each resident or the resident's representative	F 883		

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F 883	Continued From page 194 receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representativehas the opportunity to refuse immunization; and(iv)The resident's medical record includes documentation that indicates, at a minimum, thefollowing: (A) That the resident or resident's representativewas provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facilitymust develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding thebenefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representativehas the opportunity to refuse immunization; and(iv)The resident's medical record includes documentation that indicates, at a minimum, thefollowing:	F 883	1.R132, R184, R248, R311, and R324 had no ill effects. R73 was discharged from thefacility on March 15, 2023. R132 was offered the influenza and pneumococcal vaccines on 05/08/2023. R132 is his own representative, and the education of benefits and risks of the influenza vaccine was provided on 5/8/2023. R132 was reoffered the influenza and pneumococcal vaccines and education on the risks and benefits were provided on 6/5/2023. She declined. R184 was offered the influenza vaccine on 01/31/2023. She is her own representative and was educated on therisk and benefits of immunization. She declined the same day. She was reoffered the influenza vaccine, educated on the risks and benefits of the influenza vaccine, and consented to receive the 2023-2024 influenza vaccine. R 248's representatives were educated on the risk and benefits of receiving influenza and pneumococcal vaccine. Representatives consented to vaccines on 6/5/23. Resident received Pneumococcal vaccine on 6/6/23. Resident will receive the influenza vaccine. On 5/15/23, R311's representative was offered to provide consent for the influenza and pneumococcal vaccine. Education was also provided on the risks and benefits of the vaccine. The representative declined both vaccines.	6/9/2023

R324 is his own representative and was educated on the risks and benefits of the influenza and pneumococcal vaccines. R324 consented to both vaccines on 5/8/23. R324 received the pneumococcal vaccine on 05/10/2023 and will receive the influenza vaccine during the 2023-2024 flu season.

2.The Infection Control Preventionist or designee will review the current facility residents to ensure that the residents ortheir representatives were
offered opportunity to consent to influenzaand pneumococcal vaccines and that they

were educated on the risks and benefits ofthe vaccines. All Residents have the potential to be affected. Findings indicate that many residents have declined both the influenza and the pneumococcal vaccines. Education will continue to promote administration of the vaccine.

3. The Infection Control Preventionist or designee initiated education on 5/11/23 with admissions and the licensed professional nurses to offer the residents influenza and the pneumococcal per protocol and to educate the resident and/or their representative on therisks and benefits of the vaccines.

4. The Infection Control Preventionist or designee will audit admissions/readmissions to ensure that theresidents are offered the seasonal influenza and pneumococcal vaccine per protocol and to educate the Resident/RP on the risk vs benefits of the vaccines Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23.

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F 883	Continued From page 195 (A) That the resident or resident's representativewas provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidencedby: Based on record review and staff interview, for six (6) of 98 sampled residents, facility staff failedto ensure that residents were offered influenza and pneumococcal immunizations. Resident #73,#132, #184, #248, #311 and #324 The findings include ... "All adults need immunizations to help them prevent getting and spreading serious diseasesthat could result in poor health, missed work, medical bills, and not being able to care for family. All adults need a seasonal flu (influenza)vaccine every year. Flu vaccine is especially important for people with chronic health conditions, ... and older adults. Additionally, over 60 percent of seasonal flu-related hospitalizations occur in people 65 years and older. As we get older, our immune systems tendto weaken over time, putting us at higher risk forcertain diseases. This is why, in addition to the seasonal flu (influenza) vaccine and Td or Tdap vaccine (tetanus, diphtheria, and pertussis), youshould also get .... Pneumococcal conjugate vaccine (PCV15 or PCV20), which protects against serious pneumococcal disease and pneumonia (recommended for all adults 65 yearsor older who have never received a pneumococcal conjugate vaccine); if PCV15 is	F 883		

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F 883	Continued From page 196 used, it should be followed by a dose of pneumococcal polysaccharide vaccine (PPSV23), which also protects against serious pneumococcal disease." www.cdc.gov/vaccines/adults/rec-vac/index.html 1. Resident #73 was admitted to the facility on 11/30/2022, with multiple diagnoses that included Chronic Kidney Disease, Peripheral Vascular Disease, Hypertension, and Diabetes Mellitus. Review of the 5-day Minimum Data Set (MDS) assessment dated 01/17/2023, revealed that thefacility staff coded the resident as follows: -In Section C (Cognitive Patterns), "Blank" indicates "not completed." -In Section O (Special Treatments, Procedures,and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" Facility staff documented "No," -"If influenza vaccine not received, state reason" facility staff documented, "received outside of this facility"; "Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No," "If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered." Continued review of Resident #73's electronic and paper health records lacked documented evidence that facility staff provided the resident / resident's representative with information regarding the benefits and risks of immunizationsor the opportunity to receive immunizations. 2. Resident #132 was readmitted to the facility on	F 883		

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F 883	Continued From page 197 01/08/2023, with multiple diagnoses that included: Atrial Fibrillation, Diabetes Mellitus, Hypertension, Chronic Viral Hepatitis C, and Malignant Neoplasm of the pancreas and Prostate. Review of the Admission Minimum Data Set (MDS) dated 01/15/2023, revealed that the facilitystaff coded the resident as follows: -Section C (Cognitive Patterns), "8 - Moderately [cognitively] impaired" -Section O (Special Treatments, Procedures and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" Facility staff documented "No." "If influenza vaccine not received, state reason"facility staff documented, "Not offered," "Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No, " "If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered." Continued review of Resident #132's electronic and paper health record lacked documented evidence that facility staff provided the resident'srepresentative with information regarding the benefits and risks of immunizations or the opportunity to receive immunizations. 3. Resident #184 was admitted to the facility on 01/26/2023 with multiple diagnoses that included: Chronic Kidney Disease, Diabetes Mellitus, Hyperlipidemia, and Hypertension. Review of the Admission Minimum Data Set (MDS) dated 02/04/2023 revealed facility staff coded the following:	F 883		

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F 883	Continued From page 198 -Section C (Brief Interview for Mental Status), "10 - Moderately cognitively impaired" -Section O (Special Treatments, Procedures and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" facility staff documented "yes." Continued review of Resident #95's electronic and paper health records lacked documented evidence that facility staff provided the resident / resident's representative with information regarding the benefits and risks of immunizationsor the opportunity to receive immunizations. 4. Resident #248 was admitted to the facility on 10/20/2021 with multiple diagnoses that included: Hypertension, Diabetes Mellitus, Hyperlipidemia,and Cerebral Infarct. Review of the Quarterly Minimum Data Set (MDS) dated 01/18/2023 revealed facility staffcoded the following: -Section C (Brief Interview for Mental Status) summary score of " No, the Resident is rarely/never understood." -Section O (Special Treatments, Procedures and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" Facility staff documented "No." "If influenza vaccine not received, state reason" facility staff documented, "Not offered"; "... Is the resident's Pneumococcal vaccination upto date?" facility staff documented, "No," "If pneumococcal vaccination not received, state	F 883		

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F 883	Continued From page 199 reason" facility staff documented, "Not offered." Continued review of Resident #248's electronic and paper health records lacked documented evidence that facility staff provided the resident/resident representatives with informationregarding the benefits and risks of immunizationsor the opportunity to receive immunizations. 5. Resident #311 was admitted to the facility on 10/24/2022 with multiple diagnoses that included: Chronic Kidney Disease, Atrial Fibrillation, Rhabdomyolysis, and Metabolic Encephalopathy. Review of the Quarterly Minimum Data Set (MDS) dated 01/31/2023 revealed facility staffcoded the following: -Section C (Brief Interview for Mental Status) summary score of "8 -Moderately impaired." -Section O (Special Treatments, Procedures, and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" Facility staff documented "No." "If influenza vaccine not received, state reason" facility staff documented, "offered and declined. "... Is the resident's Pneumococcal vaccination upto date?" facility staff documented, "No, " "If pneumococcal vaccination not received, state reason" facility staff documented, " Not offered. " Continued review of Resident #311's electronicand paper health records lacked documented evidence that facility staff provided the resident /resident representative with information regarding the benefits and risks of immunizationsor the opportunity to receive immunizations.	F 883		

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F 883	Continued From page 200 6. Resident #324 was admitted to the facility on 12/23/2022 with multiple diagnoses that included: Diabetes Mellitus, Hypertension, and Muscle Weakness. Review of the Admission MDS dated 12/30/2022 revealed facility staff coded the following: In Section C (Brief Interview for Mental Status) summary score of "15" indicates intact cognitive response. In Section O (Special Treatments, Procedures,and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" Facility staff documented "No." "If influenza vaccine not received, state reason"facility staff documented, "Not offered, " "... Is the resident's Pneumococcal vaccination upto date?" facility staff documented, "No, " "If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered. " Continued review of Resident #324's electronic and paper health records lacked documented evidence that facility staff provided the resident/resident's representative with informationregarding the benefits and risks of immunizationsor the opportunity to receive immunizations. During a face-to-face interview conducted on 03/07/2023 at 3:00 PM, Employee #19 (Infection Control Preventionist) acknowledged the findings.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii)	F 887		

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F 887	Continued From page 201 §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policiesand procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits andrisks and potential side effects associated withthe COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum,the following: (A) That the resident or resident representativewas provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered	F 887	1.R73 was discharged from the facility on March 15, 2023. R77 was discharged from the facility on April 21, 2023. R55, R76, R184, R248, R291, R311, R324, and R327 currently reside in the facility and suffered no ill effects. The education regarding the risks and benefits of the COVID 19 vaccine was reviewed with R55. R55 provided consent to administer the vaccine on April 12, 2023. The resident received the vaccine the same day. Education regarding the risks and benefits of the COVID 19 vaccine was reviewed with the representative for R76 on April 12,2023, and consent was obtained. The COVID 19 vaccine was administered to R76 the same day. Education was provided about the risks and benefits of the COVID 19 vaccine were reviewed with R184 onApril 5, 2023. R184 declined the COVID 19 vaccine administration the same day and communicated that she received the vaccine prior to admission. The resident was not able to provide the date of administration. The representative for R248 was provided education on the risks and benefits of the COVID 19 vaccine on April 5, 2023. The representatives refused the administration of the vaccine the same day. The facility attempted to obtain consent from R291 for the COVID 19 vaccine on December 14, 2022. R291 was provided with education regarding the risks and benefits. R 291 refused the COVID 19 vaccine administration on December 14, 2022,	06/09/2023

and communicated that she received
the vaccine prior to admission to the facility.
The resident was not able to provide the date of administration.
Education on the risks and benefits of the COVID 19 vaccine were reviewed with R311 on 04/05/2023. R311 declined and communicated that she obtained the COVID 19 vaccine prior to admission. She was not able to recall the date the vaccine was administered.
Education on the risks and benefits of the COVID 19 vaccine were reviewed with R324 on April 15, 2023. The resident refused the vaccine administration the same day.
R327's representative was educated on May 8, 2023, regarding the risks and benefits of the COVID 19 vaccine and the representative provided consent. The facility scheduled R327 to receive the follow up COVID 19 dose on May 11, 2023.

2. The Infection Control Preventionist or designee will review all current residents in the facility to ensure the residents were provided the COVID-19 immunization according to the Centers for Disease Control (CDC) recommendation and manufacturer specifications as appropriate. Findings indicate the several residents continue to refuse the vaccine. Education will continue to promote vaccine administration.

3.The Infection Control Preventionist or designee will educate admission department and licensed professional nurses to ensure residents are provided the COVID- 19 immunization according to the Centers for Disease Control (CDC) recommendation and manufacturer specifications as appropriate.

4.The Infection Control Preventionist or designee will audit admissions and readmissions to ensure residents are provided the COVID-19 immunization according to the Centers for Disease Control (CDC) recommendation and manufacturer specifications as appropriate. Audits will be completed weekly x 4, then "monthly x 3. Results of the audits will be submitted to the QA and performance committee. Date of compliance 6/9/2023.

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F 887	Continued From page 202to	F 887		

the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical
contraindications or refusal; and
(vii) The facility maintains documentation relatedto staff COVID-19 vaccination that
includes at a minimum, the following:
(A) That staff were provided education regardingthe benefits and potential risks
associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers forDisease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidencedby:
Based on record review and staff interview, for ten (10) of 98 sampled residents, facility staff failed to ensure the residents were provided COVID-19 immunization according to the Centersfor Disease Control (CDC) recommendation and manufacturer specifications as appropriate (Residents #55, #73, #76, #77, #184, #248, #291,
#311, #324 and #327).

The findings included:

Guidance from the Centers for Disease Control (CDC) titled: "The Benefit Of Getting COVID-19 Vaccine", last updated 12/22/2022, documented:

-"Vaccine consent or assent for a COVID-19 vaccine is given by LTC [long-term care] residents (or people appointed to make medical decisions on their behalf, called a medical proxy)and documented in their charts per the provider'sstandard practice. Residents who receive a

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F 887	Continued From page 203 COVID-19 vaccine (or their medical proxy) also receive a fact sheet before vaccination. The factsheet explains the risks and benefits of COVID-19 vaccination. There are many benefits of getting vaccinated against COVID-19. Preventsserious illness: COVID-19 vaccines available in the United States are safe and effective at protecting people from getting seriously ill, being hospitalized, and dying. A safer way to build protection: Getting a COVID-19 vaccine is a safer, more reliable way to build protection than getting sick with COVID-1Offers added protection: COVID-19 vaccines can offer added protection to people who had COVID-19, including protection against being hospitalized from a new infection. How to be best protected: As with vaccines for other diseases, people are best protected when they stay up to date with therecommended number of doses, including bivalent boosters, when eligible. Residents (or their medical proxies) get a vaccination card or printout that tells them which COVID-19 vaccine they received and the date they received it. If theirvaccine card is full, the vaccine provider can give them another card. This should also be recorded in their medical chart." www.cdc.gov/coronavirus/2019-ncov/vaccines/re commendations/LTCF-residents.html -"The number of doses needed depends on which vaccine you receive. To get the most protection: Two (2) Pfizer-BioNTech vaccine doses should be given 3 weeks (21 days) apart, two (2) Moderna vaccine doses should be given 1month (28 days) apart, and Johnson & Johnsons Jansen COVID-19 vaccine requires only one dose." www.cdc.gov/coronavirus/2019-ncov/vaccines/.	F 887		

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F 887	Continued From page 204 Facility staff failed to ensure the residents were provided COVID-19 immunization according to the Centers for Disease Control (CDC) recommendation and manufacturer specificationsas appropriate for resident for nine (9) residents. 1. Resident #55 was admitted to the facility on 07/12/2022 with multiple diagnoses that included:End Stage Renal Disease, Cerebral Infarct, Hypertension, Diabetes Mellitus, and Epilepsy. Review of Resident #55's immunization information in the electronic and paper health record revealed, consent was confirmed, but no follow up COVID-19 vaccine dose was documented as being given. 2. Resident #73 was admitted to the facility on 11/30/2022 with multiple diagnoses that included: Chronic Kidney Disease, Peripheral Vascular Disease, Hypertension, and Diabetes Mellitus. Review of Resident #73's immunization information in the electronic and paper health record revealed, " No consent confirmed, and noCOVID-19 vaccine documented as given ..." 3. Resident #76 was admitted to the facility on 09/19/2022 with multiple diagnoses that included: Hyperlipidemia, Acute Respiratory Distress, Hypertension, and Diabetes Mellitus. Review of Resident #76's immunization information in the electronic and paper health record revealed, " No consent confirmed, and noCOVID-19 vaccine documented as given ..." 4. Resident #77 was admitted to the facility on 01/25/2023 with multiple diagnoses that included:	F 887		

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F 887	Continued From page 205 Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Hypertension, and Diabetes Mellitus. Review of Resident #77's immunization information in the electronic and paper health record revealed, "No consent confirmed, and noCOVID-19 vaccine documented as given ..." 5. Resident #184 was admitted to the facility on 01/26/2023 with multiple diagnoses that included: Chronic Kidney Disease, Diabetes Mellitus, Hyperlipidemia, and Hypertension. Review of Resident #184's immunization information in the electronic and paper health record revealed, "No consent confirmed, and noCOVID-19 vaccine documented as given ..." 6. Resident #248 was admitted to the facility on 10/20/2021 with multiple diagnoses that included: Hypertension, Diabetes Mellitus, Hyperlipidemia,and Cerebral Infarct. Review of Resident #248's immunization information in the electronic and paper health record revealed, "No consent confirmed, and noCOVID-19 vaccine documented as given ..." 7. Resident #291 was admitted to the facility on 06/14/2022 with multiple diagnoses that included: Chronic Kidney Disease, Diabetes Mellitus, Hyperlipidemia, and Heart Failure. Review of Resident #291's immunization information in the electronic and paper health record revealed, "No consent confirmed, and noCOVID-19 vaccine documented as given ..."	F 887		

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F 887	Continued From page 206 8. Resident #311 was admitted to the facility on 10/24/2022 with multiple diagnoses that included: Chronic Kidney Disease, Atrial Fibrillation, Rhabdomyolysis, and Metabolic Encephalopathy. Review of Resident #311's immunization information in the electronic and paper health record revealed, "No consent confirmed, and noCOVID-19 vaccine documented as given ..." 9. Resident #324 was admitted to the facility on 12/23/2022 with multiple diagnoses that included: Diabetes Mellitus, Hypertension, and Muscle Weakness. Review of Resident #324's immunization information in the electronic and paper health record revealed, "No consent confirmed, and noCOVID-19 vaccine documented as given ..." 10. Resident #327 was admitted to the facility on 01/10/2023 with multiple diagnoses that included: Atrial Fibrillation, Hyperlipidemia, Hypertension, and Diabetes Mellitus. Review of Resident #327's immunization information in the electronic and paper health record revealed that a first dose of the Pfizer COVID-19 vaccine was given on 1/10/2023 at [Hospital name] per discharge summary. Further review revealed that there was "No follow-up of a second dose of COVID-19 vaccine documented as given ..." During a face-to-face interview conducted on 03/07/2023 at 3:00 PM, Employee #19 (Infection Preventionist) acknowledged the findings.	F 887		

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F 919	Continued From page 207			6/9/2023
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staffwork area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidencedby: Based on observations and interview, it was determined that facility staff failed to maintain resident call system in good working condition as evidenced by the failure of the call bell system to operate correctly in two (2) of 52 resident rooms. The findings include ... During an environmental walkthrough of the facility on February 23, 2023, between 1:30 PM and 4:00 PM, and on February 24, 2023, between 10:35 AM and 12:00 PM, call bells in two (2) of 52 resident's rooms (#244 and #338) did not initiate an alarm when tested. These findings were acknowledged by Employee#6 on February 23, 2023, at approximately 4:00 PM.	F 919	1. Call bells in rooms 244 and 338 were repaired on 2/24/2023. 2. The Maintenance Director or designee will conduct resident random room audits weekly to ensurethat the call light systems are in good working condition as evidence by them being operational. All residents have the potential to be affected. Findings showed 6 call lights were defective and they were fixed right away. 3. The Maintenance Director or designee will in-service the maintenance department to ensure that the call light system in the residents' room is in good working conditionas evidenced by them being operational. 4. The Maintenance Director or designee will audit 20% of the resident rooms to ensure the call light systems are operationaland in good working condition. Audits will be conducted weekly x4 and monthly x3 and until compliance is met. Any findings and results will be corrected immediately and reviewed by the QA and performance committee. Date of compliance 06/09/23	