STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0031	A. BUILDING: _____ B. WING _____	C 03/10/2023

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CAPITOL CITY REHAB AND HEALTHCARE CENTER	2425 25TH STREET SE06 WASHINGTON, DC 20020

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L 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. During this survey, an immediate jeopardy (IJ)	L 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

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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 it was 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 while the 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 was removed 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 it was accepted. After the plan was verified the IJ was removed on February 22, 2023, at 6:40 PM while the survey team was onsite.

The following deficiencies are based on

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observation, record review, and resident and staff interviews.

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
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter

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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 Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
Q- Every
QIS - Quality Indicator Survey
RD- Registered Dietitian
RN- Registered Nurse
ROM Range of Motion
RP R/P - Responsible party
SBAR - Situation, Background, Assessment, Recommendation
SCC Special Care Center
Sol- Solution
TAR - Treatment Administration Record
Ug - Microgram

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L 001	Continued From page 4 3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview, the facility staff failed to ensure: (1) Three (3) of five (5) social workers were licensed in the District of Columbia to provide social work services. (2) One (1) of 1 licensed Social Worker was supervised by a Licensed Independent Clinical Social Worker and (3) One (1) of 1 licensed Social Worker Associate was supervised by a Licensed Independent Clinical Social Worker (Employee #29, #30, #50, #51, and #64). The findings included: 1. The facility's staff failed to ensure Employees #29, #50, and #51 were licensed in the District of Columbia to provide social work services. 1a. A review of Employee #29's (Director of Social Services) personnel file showed an offer letter date 09/07/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, full time position of Social Work commencing on September 12, 2022 ..." The offer letter was signed by the employee on 09/07/22. Further review of Employee #29's personnel file showed a "Social Worker" job description that was signed by the employee on 09/17/22. A continued review of Employee #29's personnel	L 001	1. A Licensed Independent Clinical Social Worker (LICSW) was hired 5/26/2023 who will supervise all social services employees. 2. A review of D.C. regulations related to social worker qualifications will be done by Regional social work consultant to assess the steps needed to assure compliance of current staff. All residents have the potential to be affected. Findings indicate the facility is currently in compliance with the regulations. 3. Education will be provided to the current social service department by Regional social work consultant or designee related to D.C. regulations on social worker qualifications. All social work associates will be offered an educational opportunity for potential tuition reimbursement in order to become licensed. 4.Monthly Audits x 3 and will be done of the social service department by Human Resources to assure qualifications of social worker are met prior to employment. Results of the audits will be submitted to the QA and performance committee. 5. Date of compliance: June 9, 2023	06/09/2023

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L 001	Continued From page 5 file showed a letter titled, "Change of Employment" date 11/21/22 that documented, "It am pleased to offer you the exempt, full time position of Director of Social Services effective 11/25/22 ..." The change of employment letter was signed by the employee on 11/21/22. Further review of Employee #29's personnel file showed a "Social Services Director" job description that was signed by the employee on 11/21/22. In addition, Employee #29's personnel file lacked documented evidence that the employee was licensed in the District of Columbia to provide social work services. Also, a review of the District of Columbia's professional licensing website lacked documented evidence that Employee #29 was licensed in the District of Columbia as "Social Worker". 1b. A review of Employee #50's (Social Worker) personnel file showed an offer letter date 12/01/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, full time position of Social Work commencing on December 14, 2022 ..." The offer letter was signed by the employee on 12/08/22. Further review of Employee #50's personnel file showed a Social Work job description that was signed by the employee on 12/08/22. However, Employee #50's personnel file lacked documented evidence that the employee was licensed in the District of Columbia to provide social work services. Also, a review of the District of Columbia's professional licensing website lacked documented evidence that Employee #50 was licensed in the District of Columbia as "Social Worker". 1c. A review of Employee #51's (Social Worker) personnel file showed an offer letter date	L 001		

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L 001	Continued From page 6 11/22/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, full time position of Social Work commencing on December 7, 2022 ..." The offer letter was signed by the employee on 12/05/22. Further review of Employee #51's personnel file showed a "Social Worker" job description that was signed by the employee on 12/05/22. However, Employee #51's personnel file lacked documented evidence that the employee was licensed in the District of Columbia to provide social work services. Also, a review of the District of Columbia's professional licensing website lacked documented evidence that Employee #51 was licensed in the District of Columbia as "Social Worker". During a face-to-face interview on 03/01/23 starting at approximately 12:30 PM, Employee #29, Employee #50, and Employee #51 stated during a face-to-face interview that they were unaware that they could not work as social workers in the District of Columbia without a license. Because they had a degree in Social Services, they believed they could work. During a face-to-face interview on 03/01/23 at approximately 1:00 PM, Employee #1 (Administrator) stated that he was unaware that Social Workers in District of Columbia require a license to practice. The Administrator said he believed they could work as social workers because they had a social work degree. 2. The facility's staff failed to ensure Employees #29, #30, #50, #51, and #64 were supervised by a Licensed Independent Clinical Social Worker (LICSW). 2a. A review of Employee #29's (Director of	L 001		

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L 001	Continued From page 7 Social Services) personnel file showed an offer letter date 09/07/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, full time position of Social Work commencing on September 12, 2022 ..." The offer letter was signed by the employee on 09/07/22. Further review of Employee #29's personnel file showed a "Social Worker" job description that was signed by the employee on 09/17/22. It was revealed in the job description that the employee's supervisor was Employee #1 (Administrator). 2b. A review of Employee #50's (Social Worker) personnel file showed an offer letter date 12/01/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, full time position of Social Work commencing on December 14, 2022 ..." The offer letter was signed by the employee on 12/08/22. Further review of Employee #50's personnel file showed a Social Work job description that was signed by the employee on 12/08/22. It was revealed in the job description that the employee's supervisor was Employee #29 (Director of Social Services), who is not licensed as a Social Worker. 2c. A review of Employee #51's (Social Worker) personnel file showed an offer letter date 11/22/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, full time position of Social Work commencing on December 7, 2022 ..." The offer letter was signed by the employee on 12/05/22. Further review of Employee #51's personnel file showed a "Social Worker" job description that was signed by the employee on 12/05/22. It was revealed in the job description that the employee's supervisor was Employee	L 001		

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L 001	Continued From page 8 #29 (Director of Social Services), who is not licensed as a Social Worker. 2d. A review of Employee #30's (Social Worker) personnel file showed an offer letter date 12/14/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, full time position of Social Work commencing on January 23, 2023 ..." The offer letter was signed by the employee on 01/20/23. Further review of Employee #30's personnel file showed a "Social Worker" job description that was signed by the employee on 01/07/23. It was revealed in the job description that the employee's supervisor was Employee #29 (Director of Social Services), who is not licensed as a Social Worker. In addition, the personnel filed showed that Employee #30 was licensed as a Graduate Social Worker in the District of Columbia with an expiration date of 07/31/23. 2e. A review of Employee #64's (Social Worker) personnel file showed an offer letter date 08/17/22 that documented, "It is my pleasure to extend a condition offer of employment to you ... for the non-union exempt, part time position of Social Work commencing on August 24, 2022 ..." The offer letter was signed by the employee on 08/17/22. Further review of Employee #64's personnel file showed a "Social Worker" job description that was signed by the employee on 12/29/22. It was revealed in the job description that the employee's supervisor was Employee #29 (Director of Social Services), who is not licensed as a Social Worker. In addition, the personnel filed showed that Employee #64 was licensed as a Social Work	L 001		

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L 001	Continued From page 9 Associate in the District of Columbia with an expiration date of 07/31/23. During a face-to-face Employee #1 (Administrator) interview on 03/01/23 at approximately 1:00 PM, Employee #1 stated that the facility did not employ or contract with a Licensed Independent Clinical Social Worker. In addition, the Administrator said, "We will fix this right away."	L 001		
L 035	3207.10 Nursing Facilities Dated orders and dated progress notes in the resident's medical record shall be used to document medical supervision at the time of each visit and shall be signed and dated by the resident's physician or the resident's nurse practitioner or physician assistant, with countersignature by the resident's physician. This Statute is not met as evidenced by: 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 provided medical supervision by a physician, nurse practitioner or physician's assistant at least once every 30 days for the first 90 days after admission. 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 an	L 035	1. R313 currently resides in the facility with no ill effects noted. E39 was educated that admissions/readmissions should be seen once every 30 days for the first 90 days after admission. The Medical records director or designee will view the past 30 days of admissions/readmissions to e facility to ensure that a medical provider has seen the sident at least once every 30 days after admission in e first 90 days post admission. Findings showed one sident not being seen by provider since he was mitted on 5/17/23. All Residents who are admissions/Readmissions has the potential to be affected. 3. The Educator or designee will in service the medical director and physicians to ensure that resident 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 admitted/readmitted 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 6/09/23	06/09/2023

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L 035	Continued From page 10 entry [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 seen by a physician or nurse practitioner in December 2022 but the assessment was not conducted due to an oversight.	L 035		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;	L 051		06/09/2023

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L 051	Continued From page 11 (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or hisor her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observations, record review, family interview, and staff interview, for seven (7) of 104 sampled residents, the facility's staff failed to: develop, implement and revise care plans; and 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]. Residents' #74, #131, #53, #29, #150, #60 and #313. The finding included: 1. Facility staff failed to develop a baseline careplan for Resident #74. 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 firstcare plan conference was held on 01/31/23, andthe resident's daughter signed the document to indicate she attended.	L 051	1. R74 was discharged from facility on 3/28/2023. R131'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. R53's polypharmacy care plan was initiated on 3/3/23. To address resident's potential for adverse reactions related to taking nine or more medications. R29's care conference scheduled for 05/17/2023 R150 had a care conference meeting on 03/30/2023. R60 had a care conference 4/18/23. R313's weights were documented on 3/7/23 and RP notified of significant weight loss of 5.2%. 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. 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. The Unit manager or designee will review current residents in the facility to ensure that a care plan is developed for those with short termmemory 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. The Director of social service or designee willreview current residents who had MDS completed in the last 14 days to ensure that a quarterly care planning conference was held foreach 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. 3.The DON/designee in service Dietitian on 4/7/23 to ensure that residents/ RP's are notified ofsignificant unplanned weight loss and it is documented in the medical record. 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. 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 residentswho 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. Audits willbe completed weekly x4 and then monthly x3. Results of the audits will be submitted to the QA and performance committee. 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. The Registered Dietitian or designee will review current residents with significant unplanned weight loss to ensure that residents/ Representatives were notified are. 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.	

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	HFD02-0031	A. BUILDING: _____ B. WING _____	C 03/10/2023

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L 051	Continued From page 12 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 had a baseline care meeting within 48 hours of admission, she said "No, my first care plan meeting was held on 01/31/23." 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 in the record that a base line plan was developed for the resident's admission on 11/28/22. 2. 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 the following: 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 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 behavioral symptoms. A Psychological Services Supportive Care progress note dated 07/28/22 at 8:21 AM documented, "...Met with patient today at the 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	L 051		

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L 051	Continued From page 13 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 to follow up regarding the 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 injury 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 this 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 ..." [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 issue and concern to staff.....Encourage to refrain from being aggressive towards other residents and	L 051		

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L 051	Continued From page 14 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 memory deficit 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. 3. 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 showed that the Resident was admitted to the facility on 12/11/20 with diagnoses including: Major Depressive Disorder, Paranoid Schizophrenia, Bipolar Disorder, Dementia, Epilepsy, Peripheral Vascular Disease, and Generalized Muscle Weakness. Resident #53's medical record revealed the following physician's orders: -Physician's Order dated 12/16/20 directed: "Tylenol Tablet 325 mg (Acetaminophen) Give 2 (two) tablet(s) by mouth two times a day for leg pain.	L 051		

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L 051	Continued From page 15 -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: "Eliquis Tablet 2.5 mg (Apixaban), Give 1 (one) tablet by mouth two times a day for DVT (deep vein 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 if SBP<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 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.	L 051		

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L 051	Continued From page 16 Inject 100 mg intramuscularly every evening shift starting 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 seven days 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 Decanoate Solution 100 mg/ml (milligrams/milliliter)..." Review of resident #53's comprehensive patient-centered care plan lacked documented evidence that facility staff included a 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 responsible for updating the Residents' care plans. After reviewing Resident #53's comprehensive care plan, the Employee acknowledged that there was	L 051		

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L 051	Continued From page 17 no polypharmacy care plan to address the Resident's potential risks associated with taking nine or more routine medications. 4. 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 face sheet noting Resident #29 was his/her own responsible party. The following care plan meeting notes were noted: -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 1 staff limit assist with ADL (Activities of Daily Living) care and transfers. He uses a manual wheelchair to move around independently. Skin remains intact. He remains a full code, currently does not have any placement in the community ..." -04/14/22 at 1:37 PM, "Family joined IDT meeting via phone" A review of the Quarterly Minimum Data Set (MDS) assessment dated 02/01/23, showed that the facility staff coded the resident as having	L 051		

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L 051	Continued From page 18 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 there was 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 #29 and she cannot explain why they were not done quarterly prior to 02/09/23 because she just started working at the facility. 5. Resident #150 was admitted to the facility on 02/22/18, with multiple diagnoses that included the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, and Unspecified Dementia. A review of the medical record revealed the face sheet 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 be assessed quarterly."	L 051		

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L 051	Continued From page 19	L 051		

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 3:55 PM documented, "IDT meeting held today with all the discipline and resident participate himself. Resident is alert and oriented X (times) 3 (person place 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.

6. 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 second on 05/24/22.

A review of the resident's medical record lacked documented evidence the IDT conducted care planning conferences were conducted after

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L 051	Continued From page 20 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 that the IDT should have conducted quarterly care planning conferences. 7. Facility's staff failed to notify Resident #313's family of the resident's significant unplanned weight loss of 5.2 percent from 11/12/22 to 12/21/22 [40 Days]. Resident #313 was admitted on 11/11/22 with multiple diagnoses including Dysphasia, Lewy Body Dementia, Parkinson's Disease, and Stage 4 Sacral Pressure Ulcer. A review of a nutritional assessment dated 11/13/22 documented, "Resident new admit ... wt. (weight) 105 LBS (pounds) at lower end of norm [normal] for bmi (body mass index), resident has 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 one staff member for eating.	L 051		

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L 051	Continued From page 21 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, "...compare to weight on 11/12 (105# [pounds]) lost 5.5 Lbs (pounds) (-5.2%). BMI 17.6 indicates underweight. Residents 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 about 80 pounds ..." A review of Resident #313 medical record, including progress notes and nutrition assessments from 12/21/22 to 03/06/23 lacked documented 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 that the resident's family should have been informed of her significant weight loss of 5.2%. During a telephone interview on 03/06/23 at 11:51 AM, the complainant (resident's sister) stated that	L 051		

	the resident was not eating because she didn't			

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L 051	Continued From page 22 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.	L 052	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.	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating;		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 developed a 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. The resident's yeast infection resolved. E23and E47 were educated on providing daily mouth care to residents. The straw was immediately removed from R51's meal tray. The Registered Dietician validated that the resident has an order for "no straws" in the 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. Resident 130's incontinence care was completed 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 on February 22, 2023. No signs or symptoms of infection were noted. 113's heels were offloadedimmediately	06/092023

			ɔon awareness by thenursing staff. 313 had no ill effect. The weight for 313 was obtained on 3/7/23. The eight for R60 was obtained on 3/3/23. 51 was assessed on 3/3/23 by the urse practitioner and R60 was assessed ı 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 variances and documenting interventions in place. R313 had no ill effects were 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 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. R5 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 the process to review expiration date of insulins prior to use and assuring that	

			insulin is stored appropriately. 2. The DON or designee will conduct interviews of residents and families 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 provided toileting assistance with the required number of staff as ordered, that wound care treatment are completed per orders, 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 that require incontinent care have the potential to be affected. Findings showed that residents with "no straws" orders did not receive a straw, resident requiring incontinence care were assisted by the appropriate number of staff, residents on tube feeding received oral care as ordered. The Dietician or designee will review admission/readmission weights to ensure that weights are obtained according to the facility's weight policy; residents who have a significant weight variance intervention will 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. 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) rights of medication administration, storage of insulin and the process for obtaining medications for medication administration when meds are not available. All residents has the potential to be affected. Findings showed that no medication error occurred, and that medications were properly stored. 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 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 provided toileting assistance with the required number of staff as ordered, that wound care treatment(s) are completed per orders, 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. The Nurse educator or designee will in service the nursing staff and dieticians to ensure that admission/readmission weights are 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. 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. The Nursing Educator or designee will in-service the nursing,activities, and dietary staff to ensure that the residents' meal tray tickets and the meals served are what is prescribed before they are served to each resident. 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	

			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 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 documented and residents who have 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 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. The DON or designee will audit daily x 7days any new dietary orders to ensure the dietary orders are accurate in the medical record and match the resident's meal trayticket. 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 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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L 052	Continued From page 23 (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record reviews and staff interviews, for eleven (11) of 104 sampled residents, the facility's staff failed to ensure sufficient nursing time was given to follow physician's orders and or provide care that was acceptable standards of practice evidenced by failing to: 1. provide Resident #56 with daily mouth care, resulting in extensive oral thrush (yeast infection); 2. ensure straws were provided to Resident #51 as ordered; 3. provide Resident #130 with two-person assistance during incontinent care; 4. provide Resident #493 with wound care treatments to the left hand; 5A. adequately monitor Resident #313's nutritional status and obtain an after admission and at least monthly weight to help identify and document weight loss or weight gain; 5B. safely administer medications in accordance with Standard of Practice or manufactures specifications as evidenced by Employee #22 (Agency Registered Nurse; RN) administering one unit of Novolog R insulin to Resident #313 without a physician's order on 02/10/23; 6. follow Resident #113's physician's order to offload [pro-noun] bilateral heels; 7. implement interventions to address	L 052		

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Resident #60's 40-pound weight variance from 02/11/22 to 03/07/22; 8. administer medications to Resident #494; 9. administer Resident #5 correct medications; 10. not administer expired Humalog (Lispro) insulin medication to Resident # 7; and 11. ensure Resident #255 received a pureed diet on 02/17/22. Subsequently, after eating approximately 10% of a biscuit that was provided by facility staff on 02/17/22, the resident complained of feeling the biscuit in his throat.

Residents' #56, #51, #130, #493, #313, #113, #60, #494, #5, #7 and #255.

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 the plan 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 at potential for more than minimal harm that is not immediate jeopardy for all remaining residents, at a scope and severity of E and D.

The findings included:

1. Facility staff failed to provide Resident #56 with daily mouth care, resulting in extensive oral thrush (yeast infection).

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 Vegetative

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L 052	Continued From page 25 State. 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 the Resident 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 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 that the 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 every shift. During a tour and observation of the 1 North Unit on 03/06/23 at 1:09 PM, Resident #56's	L 052		

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representative asked to speak with a surveyor in the Resident's room. Upon entering the room, the Resident'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 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 visit the 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 caused by poor oral hygiene. (https://www.mayoclinic.org/diseases-conditions/oral-thrush/symptoms-causes/syc-20353533 www.mayoclinic.com).

In addition, the Representative stated that a bump on the Resident's top right gum looked like an 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 stated that 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 weakened immune system. If it were to spread, an infection

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in [pronoun] mouth could cause serious harm like sepsis.... " The family member then told the Unit Manager to contact only the Medical Director to assess the Resident's mouth.

Review of a Nurse's Note on 03/06/23 at 2:24 PM documented: [Resident's mother] visits today with resident at the same time complained to the state surveyor during trach care/suctioning that resident has oral thrush and abscess in the mouth. In addition, RP [responsible party] reported resident wills [sp] needs to see the dentist. RP requested only [Medical Director] to do oral assessment specifically to abscess and thrush. [Medical Director] made aware with new order for Diflucan 100 mg via G tube for 5 (five) days, and [Medical Director] stated will see resident around 3pm for oral assessment. [Physician name] also made aware of dental consult for oral abscess and routing cleaning, and he will see resident on Thursday for oral examination and [physician] stated further that if the needs be, resident may have to be transfer to hospital for follow up depending on what the examination revealed, due to aspiration and swallowing precaution of Tracheostomy and gastrostomy status which is usually done in the hospital settings. Resident's RP made aware that [Medical Director] ordered Diflucan x 5 days. Further assessment will follow by [Medical Director]."
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

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care did not occur. Today was fast-paced, and we were 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 (observation and 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 risk for choking.

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 liquid

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L 052	Continued From page 29 into 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 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 from staff when eating. Review of Resident #51's medical record showed that in the "Documentation Survey Report" for February 2023, facility staff assisted the Resident with setting up the meal tray and feeding the Resident. 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	L 052		

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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 the straws on the Resident's lunch tray, the Employee stated, "We never use the straws when feeding or assisting the Resident with meals, and the 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 the trays." The surveyor showed the Employee the physician's order which stated, "...No Straws." Employee #38 acknowledged that facility staff should have checked Resident #51's meal to ensure no straws were on the Resident's tray.

3. The facility's staff failed to provide Resident #130 with two-person assistance during toileting as 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 an ADL (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

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multifactorial, spondylosis, epidural, lipomatosis, debilitation; Intervention/Tasks - Bed Mobility: [Resident's name] requires extensive assistance by (2) staff to turn and reposition in bed ...Toilet Use: [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 Mental Status summary score of "15" indicating the resident had an intact cognitive status and 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 completing assistance 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 stated Employee #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, "I grabbed 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

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CAPITOL CITY REHAB AND HEALTHCARE CENTER	2425 25TH STREET SE WASHINGTON, DC 20020

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gentle when wiping her. The resident then stated the 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 of 01/16/23 at approximately 2:00 AM, the resident 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 you will 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 when the nursing supervisor arrived, she asked "why didn't anybody tell you there were issues with the resident; have someone go to the resident's room with you; always send two people to the resident's room 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 CNA had gone to work with Resident #130 alone. Employee #32 asked the CNA if orientation on how to wash the resident's perineal area and how to attend to the resident because Resident #130

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is a 2-person assist, was provided and the CNA said no. Employee #32 stated the CNA was "substituted with other staff because the resident didn't want [Employee #31] to take care of her anymore." Employee #32 further stated, "I sent 2 other staff who went to clean the resident, requires 2 people because she a bariatric patient and has preference on who she wants to work with her; the resident is difficult to work with when the person is new to her, she likes regular staff." Employee #32 further added "normally, the Nurse for the team would have oriented the CNAs on the resident's preference, the resident has an order that for 2-person assist." Employee #32 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 was still dirty."

During a face-to-face interview with Employee #3 on 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 by the 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 revealed two physician treatment orders for the resident's left-hand dated 02/17/23. The first order instructed, "Left dorsal hand with multiple bullae

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L 052	Continued From page 34 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. Apply skin prep, then cover with abd pad and wrap with Kerli, secure with tape Q MWF every day shift every MWF." The treatment administration record (TAR) revealed a nurse's initials indicating that wound care 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) pad and 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 Q MWF every day shift every MWF." An observation was made at approximately 1:25 PM on 02/21/23 (Tuesday), showing the resident sitting 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	L 052		

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L 052	Continued From page 35 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 open lesions. 5. Resident #313 was admitted on 11/11/22. A review of the resident's medical record revealed the resident had the following diagnoses: Parkinson's Disease, Neurocognitive Disorder with Lewy Body, Adjustment Disorder with Anxiety, Dementia, Aftercare following Surgery of Skin 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). 5A. Facility staff failed to adequately monitor Resident #313's nutritional status and obtain after admission and at least monthly thereafter to help identify and document potential weight loss or weight gain. 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 time of obtained ... newly admitted residents -monitored weekly for 4 weeks. Resident with weight loss- monitor weight weekly ... All others- monitor weight monthly ...A significant change in	L 052		

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L 052	Continued From page 36 weight is defined as 5% in weight in 1 month (30 days)..." 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 deficit need 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) staff for 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 Cognitive Skills 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	L 052		06/08/2023

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L 052	Continued From page 37 12/21/22 as 99.5 pounds. 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 admission from 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 to be 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	L 052		

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L 052	Continued From page 38 02/28/23. In addition, the record lacked documented evidence that the resident refused to be weighed during that time frame. Multiple observations were conducted between 02/13/23 and 03/03/23, from approximately 8:30 AM to 4:00 PM, and showed Resident #313 lying in 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 the resident'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 ..."	L 052		

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L 052	Continued From page 39 During a face-to-face interview on 03/06/23 at 10:14 AM, Employee #11 (Dietician) stated that the resident should have been weighted weekly after the significant weight loss 5.2 percent on 12/21/22. 5B. Facility staff failed to safely administer medications in accordance with Standard of Practice or manufactures specifications as evidenced by Employee #22 (Agency Registered Nurse; RN) administering one unit of Novolog R insulin to Resident #313 without a physician's order on 02/10/23. As per the National Institute of Health, "Nursing Rights of Medication administration" [Last updated on 09/05/22], documented, "Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person 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 takes to absorb the chemical, time it takes for the drug 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	L 052		

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L 052	Continued From page 40 have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. Right dose - Incorrect dosage, conversion of units, and incorrect substance concentration are prevalent modalities of 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 MAR to 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 blood sugar 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. Review of Resident #313's medical record lacked documented evidence that 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:	L 052		

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L 052	Continued From page 41 -Percocet tablet 5-325 - give 1 tablet by mouth every 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 tablet by 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's Disease (start date 11/12/22). -Rivastigmine Patch 24-hour 4.6 MG/24HR (hour)- apply 1 patch transdermally one time a day 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 (start date 11/12/22). -Mirtazapine tablet 7.5 mg - give 1 tablet by mouth at bedtime for appetite stimulant (start date 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	L 052		

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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 insulin administration ... 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 the PCC (Point Click Care - Electronic Medical 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 went

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L 052	Continued From page 43 to 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 the room 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 nurse that 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." 6. Facility staff failed to follow Resident #113's physician's order to offload [pro-noun] 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 with the 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 bilateral heels every shift"	L 052		

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L 052	Continued From page 44 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" and that 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 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 the findings and stated, "It was left out by the CNA (certified nurse aide)." 7. Facility staff failed to implement interventions to address Resident #60's 40-pound weight variance from 02/11/22 to 03/07/22. 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 was 269 pounds on 02/11/22. A review of a physician order dated 02/11/22,	L 052		

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CAPITOL CITY REHAB AND HEALTHCARE CENTER	2425 25TH STREET SE WASHINGTON, DC 20020

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L 052	Continued From page 45 instructed, "NPO diet..." A review of an admission nursing note date 02/11/22 at 10:57 PM, documented, " ...Resident is 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 HCl 100 MG - give 1 tablet via 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-tube for 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 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 for bmi (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) Dysphagia needed to meet nutrition and hydration needs	L 052		

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L 052	Continued From page 46 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 1:41 PM, documented, "Resident peg tube [percutaneous endoscopic gastrostomy tube] was out lying on bed beside him when I walked in his room around 8:00 AM. He is stable. No apparent distress ... NP (nurse practitioner) was on the floor and assess resident with order to transfer to ER for Peg tube replacement ..." A review of a nurses note dated 02/28/22 at 10:40 PM, 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 is in 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 18 hrs=1350 ml (2025 calorie = 18 gm protein). Thiamine HCl 100 MG - give 1 tablet via G-tube one time a day for supplement."	L 052		

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L 052	Continued From page 47 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 sounds in all four quadrants), PEG site dry and clean.." A review of Medication Administration Records from 02/12/22 to 03/07/22 revealed the resident was 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). 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 "Weights and Vitals Summary" also noted Resident #60 was 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 bedside table. When asked if he enjoyed breakfast, the	L 052		

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L 052	Continued From page 48 resident shook his head indicating "yes". The resident appeared to be non-verbal. An observation on 02/17/23 at approximately 1:30 PM, noted the resident was observed lying in bed with an empty lunch tray on the bedside table. An observation on 02/21/23 at approximately 6:00 PM, 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 at 4:22 PM, Employee #57 (Dietician) was asked how she addressed variance in the resident's weight as recorded on the Weight and Vitals sheet. The employee stated that she believed the admission weight was incorrect. She informed the unit manager, so the unit manager could inform the physician. Also, Employee #57 reported that the resident no longer received tube feedings and was 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 informed him about Resident #60's 40-pound weight loss from 02/11/22 to 03/07/22. The physician stated he believed the resident's weight was inaccurate because the nurse practitioner had seen him several times during that period, and he had not displayed any other symptoms of weight loss. 8. Facility staff documented to administering	L 052		

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medications to Resident #494 that were not available in the facility.

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 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.

8A. Employee #25 (Agency RN) failed to follow special instructions (hold for diastolic blood

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pressure less than 60 millimeters of mercury) when administering Hydralazine and Carvedilol for Resident #494.

On 02/10/23 at approximately 10:00 AM, a review of 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.

Review of the resident's medical record revealed the 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 an answer.

On February 10, 2023, at approximately 10:40 AM, Resident #494 was observed in his room lying in bed. The resident was alert and oriented to 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

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L 052	Continued From page 51 02/10/23 from 8:56 AM to 9:59 PM. 8B. Employee #25 (Agency RN) failed to Follow Standards of Practice as evidenced by not ensuring Resident #494 received the prescribed dose of Hydralazine (anti-hypertensive medication). An observation of Unit 2 North's Team III's medication cart 02/10/23 starting at approximately 10:00 AM revealed Resident #494's section did not have any medications. At the time of the observation, the surveyor reviewed the resident's electronic Medication Administration Record that showed Employee #25 administered Hydralazine 25 mg on 02/10/23 at 8:00 AM. Employee #25 was asked by the surveyor, how he administered Hydralazine to Resident #494 if there were no medications in the resident's section of the cart. 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 unscored hydralazine 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. The tablet 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 because I'm an agency nurse I don't have a code to use	L 052		

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the system. I must ask the supervisor, unit manager or a staff nurse to get the medication for me."

Review of the resident's medical record revealed the 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) - 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 to be 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 not evaluated it to ensure that the two halves of a split tablet are the same in weight or drug content or 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-medicine/best-practices-tablet-splitting

Review of the "HOW SUPPLIED" section of the professional label insert for Hydralazine Hydrochloride lacked documented evidence on how to split Hydralazine tablets.

https://www.accessdata.fda.gov/drugsatfda_docs/label/1996/008303s068lbl.pdf

An observation of Unit 2 North's Omnicell on

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L 052	Continued From page 53 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/ Unit Manager) stated that Employee # 25 was not given Resident #494 another resident's medication. He should have asked her or the supervisor to remove it from the Omnicell. 8C. 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 not administered. 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 as followed: Aspirin [non-steroidal anti-inflammatory drug] 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]	L 052		

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L 052	Continued From page 54 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. 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 in the 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." 9. 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 Disorder and Acute Kidney Failure. A review of Resident #224's medical record revealed a Physician's Order dated 03/24/21 that documented "Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth one time a day 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 by	L 052		

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mouth one time a day for Neuropathic Pain at 9:00 AM." Continued review of the MAR showed staff 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.

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 then asked 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 what processes are in place for nursing staff to ensure there 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."

10. 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 ...

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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 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 accordance with accepted standards and principles ..."

Review of Resident #7's medical record revealed that 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 Diabetes Mellitus)."

Review of the Resident's medical record revealed a 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 coded for using insulin.

Review of the Resident #7's Medication Administration Record (MAR) for February 2023 showed that staff administered the resident

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L 052	Continued From page 57 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 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 vial of expired Humalog (insulin) 100 unit/ml (milliliters) that was marked with Resident #7's name. Written on the vial of insulin was an "open date 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).	L 052		

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L 052	Continued From page 58 During a face-to-face interview on 02/21/23 at 4:57 PM, Employee #9 (Registered Nurse) stated most insulin vials are used for 28 days once they are opened; unopened insulin vials are stored in the medication refrigerator. When insulin vials are first 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 medication storage room, the medication refrigerator, and the two other medication carts and did not locate any additional 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 1 South 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 the Resident 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. 11. Facility staff failed to ensure Resident #255 received a pureed diet on 02/17/22. Subsequently, after eating approximately 10% of a biscuit that was provided by facility staff on 02/17/22, the resident complained of feeling the biscuit in his throat.	L 052		

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L 052	Continued From page 59 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 gastric ulcer without hemorrhage or perforation, dysphonia, and Parkinson disease. 11A. 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 1:07 PM 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 4:36 PM 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 choking during 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,	L 052		

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L 052	Continued From page 60 substernal chest pain, increased gag response. A Speech Therapy Note dated 02/04/23 at 2:52 PM [Speech Therapy Note] documented, "Patient seen for skilled dysphagia intervention during lunch. Patient received mechanical soft lunch meal; however, most meal items more consistent 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 on downgrade 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 ...recommend follow-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	L 052		

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L 052	Continued From page 61	L 052		

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 ate the biscuit, and he stated, "Yes, and I feel like it's stuck in my throat. I've been drinking the milk to 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's meal tray.

Employee #2 (DON) was called to the bedside. She reviewed the tray card and said the resident should not have received this diet because it is a regular texture and not pureed texture, as indicated on the tray card. Employee #16 (Dietician) was called to the bedside and asked if the meal the resident had in front of him was safe for 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 02/17/23 was unsafe for the resident since the resident needed a pureed diet due to a dysphagia diagnosis.

11B. 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

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L 052	Continued From page 62 #255 was observed eating breakfast. The texture was 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 room. They all reviewed the resident's diet order and stated that the resident was to be given gravy or sauce for all meals, including breakfast. However, Employee #13 (Dietary Director) stated that 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, at 2:21 AM, the facility's Clinical Executive Director provided a corrective action plan to the State Agency Survey Team, which was accepted. Cross Reference F684, F692, F760 and F803.	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview,	L 056	1. Staffing Coordinator was made aware of the D.C. requirement related to the required staffing levels to provide direct care per day. 2. Staffing meetings held to ensure 4.1 standard is met and discuss root cause and interventions. All residents have the potential to be affected. Regional Human Resource educated staffing coordinators to ensure that HPPD is met. 3. Daily staffing sheets implemented to understand the HPPD at the beginning of each shift and respond appropriately.	06/09/2023

			4. 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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L 056	Continued From page 63 during a review of staffing [direct care and advanced practice registered nurse per Resident per day hours], it was determined that the facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per day for 23 of 23 days and sixth tenths (0.6) Advance practiced registered nurse per Resident per day for 19 of 23 days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of the Nurse Staffing was conducted on March 10, 2023, at approximately 11:00 AM. Of the 23days reviewed, 23 of the days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day, and 19 of the days failed to provide a minimum daily average of six-tenths (0.6) hours of an advanced practiced registered nurse as follows: Hours of Direct Care per resident per day Tuesday, January 11, 2022, showed that the facility provided direct nursing care per resident at a rate of 2.74 hours.	L 056		

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L 056	Continued From page 64 Friday, March 4, 2022, showed that the facility provided direct nursing care per resident at a rate of 2.07 hours. Sunday, April 17, 2022, showed that the facility provided direct nursing care per resident at a rate of 1.82 hours. Tuesday, May 3, 2022, showed that the facility provided direct nursing care per resident at a rate of 2.63 hours. Friday, May 20, 2022, showed that the facility provided direct nursing care per resident at a rate of 2.74 hours. Thursday, July 14, 2022, showed that the facility provided direct nursing care per resident at a rate of 3.11 hours. Tuesday, July 26, 2022, showed that the facility provided direct nursing care per resident at a rate of 3.13 hours. Friday, September 2, 2022, showed that the facility provided direct nursing care per resident at a rate of 2.89 hours. Friday, December 30, 2022, showed that the facility provided direct nursing care per resident at a rate of 3.45 hours. Wednesday, January 4, 2023, showed that the facility provided direct nursing care per resident at a rate of 3.05 hours. Thursday, January 14, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.94 hours.	L 056		

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L 056	Continued From page 65 Monday, January 16, 2023, showed that the facility provided direct nursing care per resident at a rate of 3.45 hours. Tuesday, January 17, 2023, showed that the facility provided direct nursing care per resident at a rate of 3.21 hours. Wednesday, January 18, 2023, showed that the facility provided direct nursing care per resident at a rate of 3.74 hours. Thursday, February 16, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.08 hours. Tuesday, February 21, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.45 hours. Thursday, February 23, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.14 hours. Friday, February 24, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.54 hours. Saturday, February 25, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.90 hours. Friday, March 3, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.90 hours. Saturday, March 4, 2023, showed that the facility provided direct nursing care per resident at a rate of 3.28 hours.	L 056		

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L 056	Continued From page 66 Sunday, March 5, 2023, showed that the facility provided direct nursing care per resident at a rate of 2.70 hours. Tuesday, March 7, 2023, showed that the facility provided direct nursing care per resident at a rate of 3.79 hours. Hours of Advanced Practice Registered Nurse per resident per day Tuesday, January 11, 2022, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.57 hours. Friday, March 4, 2022, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.53 hours. Sunday, April 17, 2022, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.33 hours. Thursday, July 14, 2022, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.58 hours. Tuesday, July 26, 2022, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.48 hours. Wednesday, January 4, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.46 hours. Thursday, January 14, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.55 hours.	L 056		

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L 056	Continued From page 67 Monday, January 16, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.58 hours. Tuesday, January 17, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.48 hours. Wednesday, January 18, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.50 hours. Thursday, February 16, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.35 hours. Tuesday, February 21, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.47 hours. Thursday, February 23, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.38 hours. Friday, February 24, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.38 hours. Saturday, February 25, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.43 hours. Friday, March 3, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.53 hours. Saturday, March 4, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.53 hours.	L 056		

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L 056	Continued From page 68 Sunday, March 5, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.51 hours. Tuesday, March 7, 2023, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.37 hours. A face-to-face interview was conducted with the Staffing Coordinator at the time of the staff review, and she acknowledged the findings.	L 056	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 5/31/2023 and by Wound manager who was in turn in-serviced by Wound NP on performing proper hand hygiene and on maintaining infection control and prevention 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 not to 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,	
L 086	3217.1 Nursing Facilities The facility shall have an Infection Control Committee composed of the Administrator or designee and members of the medical, nursing, dietary, pharmacy, housekeeping, maintenance, and other services. This Statute is not met as evidenced by: Based on observations, 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, dressing changes, and medication administration; and ensure trash and used personal protective equipment were disposed of properly. Residents' #587, #76, #75, and #313. The findings included: 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	L 086		06/092023

			mask, face shields in appropriate receptacles in the parking lot and receptacles not being over full 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 to assure that dressings were changed weekly. Findings showed no deviation from standard of practice.	

3.-The Regional clinical consultant or designee will in service the nursing staff to 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

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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(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) COMPLETE DATE
L 086	Continued From page 69	L 086		

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 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 and leave 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 cognitive status. 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 of a blood-stained gown.

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

-She used hand sanitizer and put on gloves.

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L 086	Continued From page 70 -The employee cleansed and pat dry multiple closed and open wounds on the resident's thighs. -She removed her gloves but failed to perform 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-hygiene before 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 and closed. 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, or clean 4X4. Instead, she used her gloved hands to apply 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 to the 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 care	L 086		

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L 086	Continued From page 71 while the resident laid on top of a blood-stained gown, she should have performed hand hygiene between gloves changes, and to avoid touching the resident's wound, she should have used an 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 container of ointment for the wound cart, so she won't have to 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] has potential/actual impairment to skin integrity r/t (related to) multiple wounds. Interventions- follow facility protocols for treatment for treatment of injury ..." A review of a nursing progress note dated 11/12/22 at 3:28 PM, documented, "Focus new admit 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, cover with dry dressing every day. An observation on 03/07/23 starting at approximately 10:50 AM, showed Employee #48 performed the following actions: -Gathered supplies at the bedside to provide sacral wound care. -Performed hand hygiene.	L 086		

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L 086	Continued From page 72 -Put on gloves. -Assisted Employee#49 (CNA) with repositioning 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 and tucked 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 two staff 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 stated that the stool-contaminated incontinent pad was not replaced because the stool was covered by the 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 should have 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	L 086		

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L 086	Continued From page 73 diagnoses including Sepsis, Local Skin Infections, Stage 3 Pressure Ulcer and Stage 4 Pressure Ulcer. 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 could not 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's PICC 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 clear medication cup. The employee punched the medication in the palm of ungloved hand. The employee was asked she was doing, and she stated that she was preparing Resident #76's	L 086		

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L 086	Continued From page 74 medication for administration. When asked, why did she put the resident's medication in the palm of 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 the tablet 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 provide the employee education on Infection Control during Medication Pass. 5. During observations from February 21, 2023 - March 10, 2023, revealed: -trash such as used gloves, used face masks, and used face shields, scattered throughout the facility 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.	L 086		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations and interview, it was	L 091	1. 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. No resident suffered ill effects.	06/09/2023

			2. Environmental services director or designee conducted observational rounds of the parking lot to monitor the appropriate disposals of PPE such as gloves, mask, face shields in receptacles and that receptacles are not full. 3. The Environmental Director or designee will in service the environmental service staff to ensure that the parking lot is free from scattered trash and the trash receptacles in the parking lot are not overly full of trash. 4. 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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L 091	Continued From page 75 determined that facility staff failed to provide a safe, sanitary environment, as evidenced by unhygienic, used resident care supplies such as gloves, face masks, and face shields, that were scattered throughout the facility parking lot and in one (1) of two (2) outdoor trash receptacle. The findings include: 1. Trash such as used gloves, used face masks, used face shields, were scattered throughout the facility parking lot during observations from February 21 to March 10, 2023. 2. One (1) of two (2) trash receptacles located in the facility parking lot was on numerous occasions, excessively filled with trash such as used gloves, used face masks, and used face shields from February 21 thru March 10, 2023. These findings were acknowledged by Employee #3 on March 10, 2023, at approximately 8:00 PM.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observation, record review, and resident and staff interview for five (5) of 105 sampled residents, facility staff failed to: provide food that met resident's preferences; distribute and serve foods under sanitary conditions and provide foods at the appropriate temperatures for	L 099	1. No resident suffered ill effects. Tray warmers ordered and currently in use. One Oven in use and 3 on order expected to be shipped on 05/09/2023 as per Director of 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	06/09/2023

			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 and updated on 5/5/2023 to receive double portion and preferences updated R197 was visited on 5/5/2023 and he verbalized that food is much better and that food iswarm enough to his liking. Of Note: The "always availablemenu" was updated, and new	

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L 099	Continued From page 76 consumption. 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 food preferences 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 Status for 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 get a 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 asked what processes are in place to ensure	L 099	updates will be made available on 05/09/2023. The dietician or designee visited current residents in the facility to ensure that food provided to the residents are of appropriatetemperature for consumption, and that meets the residents' preferences. All Residents has the potential to be affected. Findings showed some meal trays not at appropriate temperature and preferences not met, which were corrected right away. The Director of dietary service or designee will review the hot foods temperatures being distributed and served to residents to ensure it is done under sanitary conditions by making sure that the temperature is at least 135 degrees Fahrenheit or greater. Findings showed that 135 degrees or greater was attended. 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. 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 the temperature is at least 135 degrees Fahrenheit or greater. The dietician or designee will audit 10 %of e facility census to ensure that food	

			rovided to the residents are of appropriate mperature for consumption and based on eferences. Audits will be conducted weekly 4 and monthly x3 and until compliance is et. Any findings and results will be corrected mediately and reviewed by the QA and erformance committee. Date of compliance 09/23 The Director of dietary service or esignee will audit 10% of the food carts by sting the temperature of the last food tray to nsure that hot foods temperatures being stributed and served to residents are done nder sanitary conditions by making sure that e temperature is at least 135 degrees ahrenheit or greater. Audits will be conducted eekly x4 and monthly x3 and until compliance is et. Any findings and results will be corrected mediately and reviewed by the QA and erformance committee. Date of compliance 6/09/23 The Director of dietary services or designee will audit10% of the facility censusto ensure that food provided to the residents are of appropriate temperature forconsumption 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 perthe 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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L 099	Continued From page 77 Resident #143 receives meals that are acceptable for her consumption and according to her preferences, Employee #11 responded, "She calls and updates me with her preferences and I update 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 faster that 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 2 Diabetes 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 needing assistance with ADL's ...Interventions/Tasks - Eating: [Resident #251] requires set up assistance by (1) staff to eat." A Quarterly Minimum Data Set (MDS) assessment dated 09/02/22 documented a Brief Interview for Mental Status score of "15"	L 099		

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L 099	Continued From page 78 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 for impaired nutrition r/t (related to) therapeutic diet ... Interventions/Tasks - Diet: NCS (no concentrated sweets), double portions ...Encourage adequate po intake ...Monitor meal intake ...Update food preferences PRN (as needed)." During a face-to-face interview with Resident #251 at 1:36 PM, the resident stated, "The food is nasty. 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 documented "[Resident #79] in need of therapeutic diet due to dx [diagnosis] DM [Diabetes Mellitus], HTN [Hypertension], obesity	L 099		

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L 099	Continued From page 79 & 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 a Functional 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 service is 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 are in 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." 4. Resident #197 was admitted to facility on 02/05/2020 with multiple diagnoses that included: Benign Prostatic Hyperplasia, Muscle Weakness,	L 099		

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L 099	Continued From page 80 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 a Functional 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 09:33 AM, Resident #197 stated "the food is sometimes cold 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 are in place to ensure Resident #197 receives meals that are acceptable for consumption and according to personal preferences, Employee #11 stated, "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 Type 2 Diabetes. Review of Resident #231's medical record revealed a Care Plan dated 12/24/21 that documented "Focus - [Resident's name] has an ADL (Activities of Daily Living) self-care deficit needing assistance with ADL's r/t (related to) history of stroke, seizures, vascular dementia,	L 099		

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L 099	Continued From page 81 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 diet Regular texture, No Concentrated Sweet." A 5-day minimum data set (MDS) assessment dated 12/20/22 documented Resident #231 had a Brief 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 revealed Order Summary Report dated: -11/28/22 documenting, "Prosource one time a day 60 ml (milliliter) for protein supplement." -12/14/22 documenting, "Nepro three times a day	L 099		

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L 099	Continued From page 82 Diet supplement due to poor PO (oral) intake and weight 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 liquid for safety concerns ... the following swallow strategies are recommended: slow rate, small bites/sips, upright positioning, intermittent liquid wash." -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. She was 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 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	L 099		

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L 099	Continued From page 83 PM, the employee was asked what processes are in place to ensure residents receive meals that are acceptable for consumption and according to personal preferences. Employee #11 stated, "We don't have a selective menu for residents. We update the resident's preferences." 6. During a lunch observation on February 21, 2023, at approximately 1:30 PM, food temperatures were inadequate and failed to test at 140 degrees Fahrenheit (F) or more during a food tray test on five (5) of five (5) occasions. The following was noted: -Puree menu- Salisbury steak tested at 133.3°F (degrees Farenheit), and puree peas tested at 131.3°F -Regular menu- Salisbury steak tested at 135°F, Mashed potatoes tested at 134°F and peas tested at 137.8°F. Employee #7 acknowledged the findings on February 21, 2023, at approximately 1:45 PM.	L 099		06/09/2023
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;	L 128		

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L 128	Continued From page 84 (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d) Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e) Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: 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 through 02/23/23. (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 ..." Resident #150 was admitted to the facility on 02/22/18, with multiple diagnoses that included the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, and Unspecified Dementia.	L 128	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 reviewfor 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 ensure that 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.	

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L 128	Continued From page 85 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 cognition. The facility staff coded that the resident received antidepressant medication. The medical record lacked documented evidence that 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 resident for January and February 2023.	L 128		06/09/2023
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on review of a facility reported incident, medical records, facility documentation, and family and staff interviews, for one (1) of 104 sampled residents, the facility's staff failed to ensure expired medications were removed from use as evidenced by: not ensuring Resident #7's individual medication compartment did not contain expired Humalog (Lispro) insulin. Subsequently, the resident was administered expired Humalog (Lispro) insulin. The findings included: Review of Resident #7's medical record revealed	L 161	R7 expired Insulin Lispro was immediately disposed of on 2/10/23 and replaced on 2/11/23. Resident R7 was assessed on 2/11/23. E34 was educated on removing any medications for discharged residents 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. 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	

			properly. All Residents have the potential to be affected.	

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L 161	Continued From page 86 that 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. 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 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 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 with their 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 expired insulin 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 additional vials of insulin for Resident #7. An observation on 02/22/23 at 4:38 PM of Unit 1	L 161	3. The Nurse educator or designee will in service the licensed professional nurses to ensure that the residents' medications are stored properly in accordance with current standards of practice, that expired medications are disposed of appropriately, 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, 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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L 161	Continued From page 87 South Team 1's medication cart revealed a vial of expired Humalog (insulin) 100 unit/ml (milliliters) that was marked with Resident #7's name. Written on the vial of insulin was an opened date of 01/19/23 and an expiration date of 02/16/23. Cross reference F760 and 22 B DCMR sec 3211.1.	L 161		06/09/2023
L 162	3227.13 Nursing Facilities Each medication that is no longer in use shall be destroyed or returned to the in-house pharmacy. This Statute is not met as evidenced by: Based on review of a facility reported incident, medical records, facility documentation, and family and staff interviews, for one (1) of 104 sampled residents, the facility's staff failed to ensure tht medication that is no longer in use was destroyed or returned to the pharmacy as evidenced by: Employee #34 failed to ensure Resident #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]. The findings included: 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 one time a day for neuropathic pain." An observation of Team 2's medication cart on	L 162	1.R224. Gabapentin belonging to resident 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 resident R224 are present in his 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, 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 slot which was 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 to ensure that the residents' medications are stored properly in accordance with current standards of practice, 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 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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L 162	Continued From page 88 Unit 2 south on 02/10/23 at approximately 10:00 AM revealed Resident #224's medication section included a blister pack of Gabapentin 300 mg belonging to Resident #488. The medication cart lacked evidence of Gabapentin for Resident #224 at 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 by mouth one time a day for Neuropathic Pain at 9:00 AM." Continued review of the MAR showed Employee #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 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." The employee was then asked did she administer Resident #224's Gabapentin 300 milligrams on this date, 02/10/23, at 9:00 AM. Employee #34 said, "Yes." It should be noted Resident #488 was discharged from the facility in December of 2022. Cross reference F 760 and DCMR 22 B Sec 3211.1	L 162		
L 200	3231.11 Nursing Facilities Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification. This Statute is not met as evidenced by:	L 200		06/09/2023

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L 200	Continued From page 89 Based on observation, record review and staff interview for one (1) of 105 sampled residents, facility staff failed to provide sufficient nursing time to Resident #231 to ensure proper care to minimize pressure ulxcers and promote the healing of ulcers. 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 Type 2 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 of skin 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 was a 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." Review of Resident #231's medical record revealed a Care Plan dated 12/24/21 that documented "Focus - [Resident's name] has limited physical mobility, Goal - [Resident's name] will remain free of complications related to	L 200	1. R231 was discharged from the facility on 04/25/2023. RE27 educated 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 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	

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L 200	Continued From page 90 immobility, including ... skin-breakdown through the next review date in 90 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 ..." Review of Resident #231's medical record revealed a Care Plan dated 12/24/21 that documented "Focus - [Resident's name] has an ADL (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 - Skin Inspection: [Resident's name] requires SKIN inspection as ordered. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse." Review of Resident #231's medical record revealed physician's orders dated 01/12/22 at 2345 (11:45 PM) 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)" ... "Has resident been assessed for change of condition? every shift." Review of Resident #231's medical record revealed an SBAR (Situation, Background, Assessment/Appearance, Request) - Physician/NP (nurse practitioner)/PA (physician assistant) Communication Tool dated 11/22/22 at 13:00 (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 whether the problem/symptom has gotten worse/better/stayed the same since it started: Worse."	L 200		

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L 200	Continued From page 91 Review of Resident #231's medical record revealed a Nurses Progress Note dated 11/22/2022 at 13:55 (1:55 PM), that documented "Resident was noted 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." Review of Resident #231's medical record, it revealed a document titled Tissue Analytics (wound evaluation) dated 11/30/2022 at 09:38 AM that 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; Pressure Reduction/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. Review of Resident #231's medical record revealed 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, continue with at risk skin care plan interventions."	L 200		

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L 200	Continued From page 92 Review of Resident #231's medical record revealed an Order Summary Report dated 11/23/22 that documented "Cleanse wound with NS - pat dry, apply silver alginate and cover with 4x4 gauze until healed two times a day for wound healing." Review of Resident #231's medical record revealed an Order Summary Report dated 11/23/22 that documented "Sacrum: Clean with normal saline, pat dry apply silver alginate and cover with dry dressing every day shift for wound care, Start Date 11/24/2022" indicating no site was specified on the previous Order Summary Report. Review of Resident #231's medical record revealed a 12/14/22 Discharge Summary from a local hospital that noted the Resident was discharged from the dialysis facility on 12/02/22 and was brought in to the local ED (emergency department) 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), sacral ulcer wound stage III, and right heel ulcer. Upon further discussion with family, [pronoun] mental status was similar to baseline. Patient is s/p (status post) sacral wound debridement on 12/5/22 and wound cultures grew proteus (susceptible to meropenem) and e. faecalis (susceptible to vancomycin). Patient was treated with IV (intravenous) Meropenem 0.5g (grams) daily and Vancomycin dosed with dialysis - start date 12/2/22. Patient was seen by wound care during her hospital stay." A 5-day minimum data set (MDS) assessment dated 12/20/22 documented Resident #231 had a Brief Interview for Mental Status score of "00"	L 200		

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L 200	Continued From page 93 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 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." During a face-to-face interview on 02/22/23 at 04:54 PM with the RP (responsible party/Resident's daughter) of Resident #231, the daughter stated the resident "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 asked if they've been turning [pronoun] often." During a face-to-face interview on 03/10/23 at 9:00 AM with Employee #27, [pronoun] stated "No one told me about the sacrum ...Why is it harm? Is it because it was Unstageable when it was found? But the Unstageable can turn out to be anything. Employee #27 was asked if the staff were doing regular skin assessments and [pronoun] responded, "We were doing skin checks, but it's been a while since they were done, for some months now. The charge nurse is supposed to do skin sweeps (checks) during showers, but not sure if being done." During a face-to-face interview on 03/10/23 at 11:32 AM with Employee #3, [pronoun] was told that the ADON was not aware of the new sacral	L 200		

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L 200	Continued From page 94 wound for the Resident on the unit and [pronoun] stated "[Pronoun} might not have been here for the IDT (Interdisciplinary Team) Meeting that's why [pronoun] probably wasn't aware. Employee #3 was asked if they have access to wound care reports and [pronoun] responded, "We see the same thing in the record that you see, we get the report from Healing Partners and make recommendations from there. We spoke with Healing Partners because it seems as though she had a DTI (deep tissue injury), but opened up to a Stage 3, but I acknowledge that there was no documentation of assessments being done starting at a DTI before it progressed to that point of Unstageable pressure ulcer." Follow-up interview with Employee #27 to clarify treatment orders when the new sacrum pressure ulcer was first noted. [Pronoun] stated, "It didn't have the site for the first order then it was corrected to add the site at the Sacrum from the time we first saw it, this is the date of the order [11/23/2022]."	L 200		06/09/2023
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a) The resident's name, age, sex, date of birth,race, marital status home address, telephone number, and religion; (b) Full name addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor. (c) Medicaid, Medicare and health insurance numbers;	L 201		

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L 201	Continued From page 95 (d) Social security and other entitlement numbers; (e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f) Date of discharge, and condition on discharge; (g) Hospital discharge summaries or a transfer form from the attending physician; (h) Medical history and allergies; (i) Descriptions of physical examination, diagnosis and prognosis; (j) Rehabilitation potential; (k) Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l) Current status of resident's condition; (m) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n) The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was	L 201	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, 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/representative 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 or family members 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 advanced directive. All were offered the opportunity to complete the advanced directive although two residents declined. 3. The Social worker director or designee will in service the social worker staff to ensure that residents or family members 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 residents or family members 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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L 201	Continued From page 96 discharged; (o) Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q) The plan of care; (r) Consent forms and advance directives; and (s) A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on observation, record review, and staff interviews for eight (8) of 105 sampled residents, facility staff failed to ensure that each resident's medical record included consent forms and advance directives. 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 2 Diabetes, 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 a	L 201		

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L 201	Continued From page 97 moderately 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 (DC Medical Orders for Scope of Treatment) form that states, "...The MOST does not replace an advanced directive ...An advance directive is encouraged for all competent adults regardless of their 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 acknowledged the 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, [pronoun] 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 and 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. The resident 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 the	L 201		

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L 201	Continued From page 98 advance directive in Resident #286's medical record, [pronoun] responded, "Are you looking for the code status?. This is what we send out for their code status [pointing to the blank MOST form in the physical chart]. Yes, this is the form, 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 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 MOST form 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 and the 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 2 Diabetes Mellitus and Chronic Kidney Disease. An observation on 02/13/23 at approximately 11:00 AM showed the resident was in bed watching television. The resident was asked if the facility's staff provided [pro-noun] with written information regarding formulating an Advanced Directive? The resident stated, "No."	L 201		

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L 201	Continued From page 99 A review of an admission Minimum Data Set dated 01/27/23 documented the resident had a Brief Interview for Mental Status summary score of "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 to formulate an Advanced Directive. 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 provide all residents with a copy of the document on admission. However, when the surveyor showed the resident the "Advance Directives" document on the same day at approximately 2:10 PM, the resident stated, "I did not get a copy of this document." 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, and Other Reduced Mobility. It was noted on Resident #101's face sheet that the resident is his own responsible party and that 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 status should not be conducted, and that the resident has both a short term and long term memory problem.	L 201		

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L 201	Continued From page 100 Resident #101's medical record lacked documented evidence that the facility's staff offered the resident an opportunity to formulate an advanced directive. During a face-to-face interview conducted on 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 company owned 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 the following: It was noted on Resident #272's face sheet that the resident is their own responsible party 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 formulate an 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 (DC Medical Orders for Scope of Treatment) form in the chart was the advanced directive.	L 201		

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L 201	Continued From page 101 The surveyor showed Employee #14 on the (MOST) Form that it is not an Advanced Directive or an offer of an Advanced Directive. 5. 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 following: It was noted on that Resident #29's face sheet indicates that the resident has a responsible party and the resident was a full code. A review of the Quarterly Minimum Data Set (MDS) dated 02/01/23, showed that the 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 formulate an advanced directive. During a face-to-face interview conducted on 03/03/23 Employee #14 (Unit Manager 3 South) stated that she does not know where the paperwork (Offer of Advanced Directive) is but it should be in the chart. 6. 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, and Other Reduced Mobility. It was noted on Resident #101's face sheet that	L 201		

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the resident is his own responsible party and that 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 status should not be conducted, and that the resident has 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 formulate an advanced directive.

During a face-to-face interview conducted on 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 company owned the facility.

7. 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 the following:

It was noted on Resident #272's face sheet that the resident is their own responsible party 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

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documented evidence that the facility's staff offered the resident an opportunity to formulate an 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 (DC Medical Orders for Scope of Treatment) form in the chart was the advanced directive.

The surveyor showed Employee #14 on the (MOST) Form that it is not an Advanced Directive or an offer of an Advanced Directive.

8. 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 following:

It was noted on that Resident #29's face sheet indicates that the resident has a responsible party and the resident was a full code.

A review of the Quarterly Minimum Data Set (MDS) dated 02/01/23, showed that the 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 formulate an advanced directive.

During a face-to-face interview conducted on 03/03/23 Employee #14 (Unit Manager 3 South) stated that she does not know where the

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 201	Continued From page 104 paperwork (Offer of Advanced Directive) is but it should be in the chart.	L 201	1. R237 currently resides in the facility and has no ill effects noted. 2. The Director of nursing or designee will review fall incidents in the last 30- days to assure that investigations are completed to rule out abuse, neglect and injuries of unknown source. Findings indicated that all falls were investigated appropriately. All residents who fell in the last 30 days have the potential to be affected. 3.The Nurse educator or designer 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. 4.The Director of nursing or designer will review incidents related to falls to ensure that the facility's policies and procedures for investigating allegations of abuse, neglect, and injuries of an unknown source are followed. All issues will be addressed immediately. Audits will be completed weekly x4 and then monthly x3. Results of the audits will be submitted to the QA	06/09/2023
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c) The statement of the victim; (d) A statement indicating whether there is a pattern of occurrence; and (e) A description of the corrective action taken. This Statute is not met as evidenced by: Based on record reviews and staff interviews for 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 by not having a complete summary and analysis 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	L 204		

			and performance committee. Date of compliance June 09, 2023.	

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L 204	Continued From page 105	L 204		

the investigation on determining if abuse, neglect, exploitation and or mistreatment has occurred, the extent and cause and providing complete and thorough 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 ...within specified timeframes ..."

Facility staff failed to report Resident #237's fall that the resident reported to staff that occurred when the resident was walking back to the facility from the community.

Resident #237 was admitted to the facility on 12/03/21 with multiple diagnoses that included the following: Asthma, Heart Failure Unspecified, and Other 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 physical assist for locomotion on and off the unit, and 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, "reident (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. Pt ststed (sp) (stated) "I tripped on something on my way back to the facility and stained my left shoulder while I tried to prevent from falling" RN

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L 204	Continued From page 106 (registered nurse) assessed resident and no sign of 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 per patient report and on assessment no physical injury noted on examination ..." -[Incident Note] 09/19/22 at 2:41 "A follow-up was 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 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 on which is inappropriate for outside terrain ...DNP (Doctor Nurse Practitioner) made aware and she gave an	L 204		

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L 204	Continued From page 107 order 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.	L 204		06/09/2023
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record reviews and staff interviews for one (1) of 105 sampled residents, facility staff failed to report an injury of an unknown source to the State Agency in a timely manner and per their policies and procedures. (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,	L 206	1.R237 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 inthe 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. 4. The Director of Nursing/designee will review incidents of unknown source to assure that the incident was reported to theState 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	

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L 206	Continued From page 108 exploitation and or mistreatment has occurred, the extent and cause and providing complete and thorough 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 ...within specified timeframes ..." Resident #237 was admitted to the facility on 12/03/21 with multiple diagnoses that included the following: Asthma, Heart Failure Unspecified, and Other Abnormalities of Gait and Mobility. A review of the medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 09/08/22, showing that the facility staff coded the resident as cognitively intact, needing supervision and a one-person physical assist for locomotion 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 my way back to the facility and stained my left shoulder while I tried to prevent from falling," RN (registered nurse) assessed resident and no sign of 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 ..."	L 206		

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L 206	Continued From page 109 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 pain is 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 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 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 on which is inappropriate for outside terrain ...DNP (Doctor Nurse Practitioner) made aware and she gave an order for thoracic/lumbar x-ray (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 on	L 206		

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L 206	Continued From page 110 9/16/22 which was reported on 9/19/22" The medical record lacked documented evidence that 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.	L 206		06/09/2023
L 211	3233.4 Nursing Facilities The Administrator or designee of each facility shall review each grievance filed within seventy-two (72) hours of its filing and shall respond in writing to the resident or the Resident's Representative within five (5) business days. This Statute is not met as evidenced by: Based on observations, record review, resident interview and staff interview, the facility's staff failed to ensure residents received written decisions regarding grievances that were filed. 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 decision on the grievance to the resident or representative at the conclusion of the investigation. A review of the facility's Grievance Book revealed	L 211	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 available to file grievances anonymously. Resident council will be informed on 06/01/2023 about locked boxes being available on floors to anonymously file grievances and informed that facility will provide written follow up to their grievances. 2Grievances 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. The Social Worker Director or designee will review grievances to assure that a written follow upis 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 committee. Date of compliance 06/09/23	

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L 211	Continued From page 111 a 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 with a 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 had filed many grievances, but he had not received a written 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 to submit their complaints to the nursing staff, who then sent them to the Grievance Officer. 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 of the 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 responded to residents' grievances verbally and was not aware of documentation requirements.	L 211		

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L 214	Continued From page 112	L 214		06/09/2023
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on February 21, and February 22, 2023, at approximately 9:30 AM, it was determined that facility staff failed to provide an environment that is free from accident hazards, as evidenced by two (2) of two (2) portable space heaters in the clean linen area of the facility and several cracks from the concrete driveway and sidewalk, located at the entrance of the facility, that presented a tripping hazard to residents, staff, and visitors. The findings include: 1. Two (2) of two (2) portable space heaters were seen in the clean linen area of laundry services. 2. Numerous cracks in the concrete driveway and sidewalks, at the front of the facility, presented an accident hazard to residents, staff, and visitors. These findings were acknowledged by Employee #6 on February 22, 2023, at approximately 11:00 AM.	L 214	1. The portable space heaters in the clean linen 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 Environmental service director or designee will review the clean linen area of laundry services to ensure that there are no portable space heaters present. The Maintenance director or designee will repair the concrete driveway and sidewalks . 3. 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 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 environmental services or designee will audit	
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating	L 306		

			the clean linen area of laundry to ensure that there are no portable space heaters present. 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. All issues will be corrected immediately. Audits are conducted weekly x4 and then monthly x3. Results of the audits will be submitted to the QA and performance committee. Date of compliance June 09, 2023.	

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L 306	Continued From page 113 signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b) In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c) Be of a quality which is, at the time of installation, consistent with current technology; and (d) Be in good working order at all times. This Statute is not met as evidenced by: 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's 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, #338) did not initiate an alarm when tested. These findings were acknowledged by Employee #6 on February 23, 2023, at approximately 4:00 PM.	L 306	1. Call bells in rooms 244 and 338 were repaired. 2. The Maintenance Director or designee will conduct resident room audits to ensure that the call light systems are in good working condition as evidence by them being operational. Six call lights were defective and were fixed immediately. All residents have the potential to be affected. 3. The Maintenance Director or designee will in-serve the maintenance department to ensure that the call light system in the residents' room is in good working condition as evidence of it being operational. 4. The Maintenance Director or designee will audit 20% of the resident rooms to ensure the call light systems are operational and in good working condition weekly x 4, then monthly x 3.All issues will be corrected immediately. Results of the audits will be submitted to the QA and performance committee. Date of compliance June 09, 2023.	06/09/2023
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and	L 410		

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L 410	Continued From page 114 maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to provide housekeeping services necessary to maintain a safe, clean, and comfortable environment, as evidenced by torn privacy curtains in eight (8) of 52 resident's rooms, soiled exhaust vents in 15 of 52 resident's rooms, trash thrown throughout the facility parking lot between February 21 and March 10, 2023, two (2) of two (2) overly packed trash cans in the facility parking lot, and expired dental items in the dental office. 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 the following were observed: 1. Privacy curtains in resident's rooms#106, #147, #158, #159, #160, #257, #307, #330, eight (8) of 52 resident's rooms. 2. Exhaust vents located in the bathroom of resident's rooms #143, #152, #159, #217, #227, #228, #250, #308, #315, #329, #333, #337, #348, #351, #352, 15 of 52 resident's rooms. 3. Trash such as used gloves, used face masks, used face shields, empty plastic containers, and various debris were scattered throughout the facility parking	L 410	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 lotis 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 on 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' room are not torn, and that the parking lot is free from scattered trash and the trash receptacles in the parking lot are not overly full of trash.	06/09/2023

			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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	HFD02-0031	A. BUILDING: _____ B. WING _____	C 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 410	Continued From page 115 lot during observations from February 21 to March 10, 2023. 4. Two (2) of two (2) trash receptacles located in the facility parking lot were excessively filled with trash filled on various occasions during observations from February 21 to March 10, 2023. 5. Several items used in the dental office were expired including: Two (2) of two (2) unopen 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. 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 label torn. 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.	L 410		

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L 426	Continued From page 116	L 426		06/09/2023
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made on February 27, 2023, at approximately 9:15 AM, it was determined that facility staff failed to maintain an effective pest control program, as evidenced a crawling pest observed on a sofa chair located in the conference room on the third floor(chapel). The findings include ... A crawling pest was seen on a sofa chair on the third-floor conference room on February 27, 2023, at 9:19 AM. These findings were acknowledged by Employee #3 on March 10, 2023, at approximately 8:00 PM.	L 426	1. Pest was discarded and the area was cleaned on day identified. 2. On going staff in-service on steps to take if a pest is identified. All residents have the potential to be affected. Findings indicated that no other pests were found in the facility. 3. Bay city (pest control company) visits the facility weekly and performs pest control treatments 4. Weekly audits on-going to check pest log and follow-up appropriately. All issues will be corrected immediately. 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	
L 520	3269.1c Nursing Facilities (c) To either manage his or her own personal finances, or be given a quarterly report of the his or her finances if this responsibility has been delegated in writing to the nursing facility; This Statute is not met as evidenced by: 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 to adhere to generally accepted accounting principles when acting as a manager (representative payee) for the resident's personal	L 520		

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L 520	Continued From page 117 funds (social security benefits). (Resident #229). The findings included: Resident #229 was admitted to the facility on 10/25/22 with diagnoses that included 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 refused to 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 manage funds in the future (for example the patient is temporarily unconscious)? "No". Further review of the document showed Employee #53 (Business Office Manager) signed as the applicant applying for representative payee for Resident #229.	L 520		06/09/2023

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L 520	Continued From page 118 A review letter for the Social Security Administrator dated 02/16/23 documented, " We 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 institution or account you selected ..." A review of a document titled, "Resident Statement Landscape" showed the facility received Resident #229's social security benefits twice on 02/07/23 and 03/03/23 after applying for rep-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, leaning on the bedside table, looking down. When asked if everything was okay, the resident stated, "No, I don't have any money. They took my money, and I didn't sign papers for them to do that." When asked, who took her check, the resident stated it was 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 related to that practice, she stated, "No, the corporate office told me to do that." When asked, if the facility's Administrator also told her to implement that practice when applying for rep-payee, she stated, "No". During a telephone interview on 03/07/23 at 1:20 PM, Employee #1 (Administrator) stated, "Under no circumstance should she (Employee #53)	L 520	1. R229 consented to facility as representative payee for resident personal funds on 3/7/23. E53 was educated on acceptable accounting principles when acting as a representative payee for resident personal funds. 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 or designee on 5/18/23 to assure that facility adheres to acceptable 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. 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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L 520	Continued From page 119 apply for rep-payee if the resident refuses for us the be rep-payee."	L 520		06/09/2023
L 529	3269.1l Nursing Facilities (l) To be free from mental or physical abuse; This Statute is not met as evidenced by: Based on observations, record reviews, and staff interviews for seven (7) of 105 sampled residents, the facility staff failed to ensure residents were free from abuse prevent residents from abuse. Residents #146, #163, #254, #247, #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 assessment if 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 protected	L 529		

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L 529	Continued From page 120 from 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 the occurrence (s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; Defining 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 physical altercations with Resident #70 and Resident #131. A review of a Facility Reported Incident (FRI) submitted by the facility to the State Agency on 10/28/22, documented "... On Monday October 24, 2022, at approximately 8:40 am, an alleged resident to resident physical altercation occurred in front of the first-floor elevators. [Resident #70] allegedly hit resident [Resident #169] in the face." A review of a Facility Reported Incident (FRI) submitted by the facility to the State Agency on 01/19/23 documented "... Report received that at 2:50pm that resident [Resident #169] was involved in a physical altercation with another resident. [Resident #169] sustained a skin tear to his right lower leg, and an abrasion to his right forehead... " A review of a Facility Reported Incident (FRI) submitted by the facility to the State Agency on 01/24/23, documented, "... On January 19, 2023,	L 529	1.R146, R163, R 254, R70, R131, and R169 currently reside in the facility offered emotional support and no ill 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. R 247 had no injuries noted. 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 sexual desires/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 evidence 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.	

			4. The Director of nursing or designee will review facility reported incidents (FRI) relatedto 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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L 529	Continued From page 121 at approximately 2:50 pm, an alleged resident-to-resident physical altercation occurred between residents (Resident #169 and Resident#131) ...hit each other while on the smoking patio. The residents were immediately separated by staff ...Based on the full investigation and witness statements, the facility substantiates the alleged resident-to-resident physical altercation ..." A review of a Facility Reported Incident (FRI) submitted by the facility 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. Resident #169 was admitted to the facility on 01/03/19 with multiple diagnoses that included the following: Tobacco Use, Unspecified Dementia, and Altered Mental Status. Review of Resident #169's medical record revealed the following: Review of a care plan initiated on 05/25/22 with a focus 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	L 529		

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L 529	Continued From page 122	L 529		

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 ..."

A review of the Quarterly Minimum Data Set (MDS) dated 09/11/22 showed that the facility staff coded the following: severe cognitive impairment, Physical behavioral symptoms directed towards others (e.g.(for example) hitting, 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 or living environment. The facility staff coded the resident as having no impairment in the upper or lower extremity.

[SBAR (situation background assessment recommendation) -Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool] dated 09/17/22 at 4:54 PM, " ...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 ..."

SBAR (situation background assessment recommendation) -Physician/NP (Nurse

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L 529	Continued From page 123	L 529		

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

[Nurses Note] dated 10/24/22 at 12:38 PM " ...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 or bruise noted on [Resident #169] was noted with a bump 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, with a 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 ..."

[Nurse Progress note] dated 01/19/23 at 5:02 PM, "Report received around 2:50 PM resident was involved in a physical interaction with another male resident. Resident sustained minor injury to his right forehead, and right lower leg ..."

[Progress Note] dated 01/19/23 at 6:51 PM "... [Provider Name] was notified and order given as follows , Right forehead abrasion-Cleanse with NSS (Normal Saline Solution) pat dry apply bacitracin (Topical antibiotic ointment) leave open to air. Right lower leg skin tear- cleanse with NSS (Normal Saline Solution) pat dry ...[Resident #169] was interviewed, he stated that the guy

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L 529	Continued From page 124 punch him on his face and he did not know he hit him and stated that he hit back....." [Nurse Progress Note] dated 02/16/23 at 12:26 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 [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, documents the following focus area: "[Resident #169] has a behavior r/t (related to) wandering on the hallways, attempting to enter other resident's rooms/ 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." had the following interventions "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 situation and take to alternate location as needed. Review of a document provided by the facility titled "smoking monitors" dated 02/23/23, listed the Resident #169's name and 6 other Residents' names and stated "When these residents are on the smoking patio or waiting to enter the smoking patio, please monitor them to ensure they do not interact negatively with other residents." There was no documented evidence in the medical record that the facility provided interventions in the care plan to address the residents' symptoms of Dementia that lead to multiple altercations with other residents.	L 529		

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L 529	Continued From page 125 During a face-to-face interview conducted on 02/28/23 at 12:55 PM, Employee #18 (Unit Manager 3 South) acknowledged the findings and stated, "(Resident #169) was actually asking everyone for a puff of their cigarette. They started tussling (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 #169 were engaged in a physical altercation. Resident #70 was admitted to the facility on 08/05/2013 with multiple diagnoses that included the following: Disorder of the Brain, Bipolar Disorder, Restlessness and Agitation, Schizoaffective Disorder, and Difficulty Walking. 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] refused assessment. It in (is) unknow (sp) where [Resident #169] was hit as [Resident #70] did not disclose. 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 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	L 529		

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L 529	Continued From page 126 resident had no impairment of the upper or lower extremity. [Nursing Progress Note] 10/24/22 at 3:45 PM " ... [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 ..." [Psychiatric Progress Note with Therapy Services] 10/24/22 at 8:00 PM, " ...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 that transpired 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. During a face-to-face interview conducted on 02/28/23 at approximately 1:15 PM Employee #3 (Director of Nursing) stated that when we have a resident-to-resident physical altercation we separate them. 3. Facility staff failed to prevent Resident #131 from repeated episodes of abuse due to	L 529		

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L 529	Continued From page 127	L 529		

inadequate supervision which resulted in physical altercations with Resident #254 and Resident #169.

Resident # 131 was admitted to the facility on 02/03/17 with multiple diagnoses that included the following: 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 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

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L 529	Continued From page 128 following: [Physician Order] 10/20/21 "Monitor for: Specify behaviors yelling, screaming, resisting care, applying soap to his body, anxious document in progress notes every shift ..." A review of Resident #131's Quarterly Minimum Data Set (MDS) dated 07/24/22, revealed that the facility 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 at 8:46 PM "The nursing staff reported that the patient had a physical Altercation with another in-house patient [Resident #254] and sustainedan injury 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 (status post) ER transfer: Resident returned to unit @1:30pm from hospital transfer. Resident has hematoma of the left eye as well as a laceration above left eye that he received stitches. Resident denies any pain at this time. Residents vitals were 154/90, (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."	L 529		

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L 529	Continued From page 129 [Treatment Administration Record (TAR)] 07/27/22, " ...Left below eye laceration repaired site: Apply Bacitracin (topical antibacterial) to site every 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 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 ..." [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 sustain any injuries ..." [Nursing Progress Note] 01/19/23 at 7:39 PM " ... [Resident #131] was seen to follow up regarding the 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 injury noted, he stated that he is fine ..." [Care Plan] initiated on 1/19/23, Focus :"[Resident #131] has a physical aggression with other resident [Resident #169] while in a smoking patio" 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."	L 529		

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L 529	Continued From page 130 [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 where about 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 where abouts 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 ..." [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 issue and concern to staff.....Encourage to refrain from being aggressive towards other residents and report any disagreement he has with other residents to staff..."	L 529		

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L 529	Continued From page 131 [Incident Note] 02/18/23 at 12:37 AM " ...IDT (interdisciplinary team) had a meeting regarding Mr. [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 any disagreement 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 patio or 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 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 asked him 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.	L 529		

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L 529	Continued From page 132 During a face-to-face interview conducted on 02/28/23 at 2:11 PM, Employee #40 (Smoke Monitor) stated that the altercation started outside after [Resident #169] asked [Resident #131] for a puff of his cigarette then more words were exchanged, and the residents started to fight. Review of the facility's policy entitled "Abuse, Neglect and Exploitation," revised 09/2022, shows: "It is the facility's policy to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse ...Definitions "Abuse" means the willful infliction of injury ... with resulting physical harm, pain or mental anguish, which can include ...staff- to- resident abuse and certain resident-to-resident altercations. Sexual Abuse is non-consensual contact of any type with a resident. Physical Abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking...." 4. Facility staff failed to prevent sexual abuse (non-consensual contact) of one resident (Resident #146) towards another resident (Resident # 163) when the assigned staff diverted attention away from Resident #163. A.Review of Resident #163's medical record revealed the Resident was admitted to the facility on 05/18/20 with diagnoses including: Cerebrovascular Accident, Hemiplegia, Type 2 Diabetes Mellitus, Depression, and Anxiety. Review of the Resident's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 02/18/23 documented a Brief Interview for Mental Status (BIMS) summary score of "15", indicating that the Resident had	L 529		

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intact cognition. In addition, the MDS assessment noted that the Resident had lower extremity impairment on one side, used a wheelchair for mobility, and required supervision (oversight, encouragement, and cueing), by facility staff for locomotion on and off the unit.

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 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 ...Psych consult due to alleged abuse."

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 Recommendations: ...Continue with behavioral

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L 529	Continued From page 134 monitoring." Review of the Resident's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 09/27/22, which documented a Brief Interview for Mental Status (BIMS) summary score 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 Resident could 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 to anybody' ... 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 that [Resident #146] touch(ed) [pronoun] on [pronoun] chest while on the first-floor dining (sp.)	L 529		

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(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 are talking 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 ... [Resident #146] was interviewed by the clinical manager. When [pronoun] was asked about what occurred [pronoun] stated, 'I don't know. What

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L 529	Continued From page 136 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 ...provider for 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]." 02/27/23 at 10:AM [Psychiatric Progress Note]: " ...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 allegation was 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 resident to resident alleged sexual assault reported by [Resident #163] at 9 PM on February 21, 2023. An eyewitness saw [Resident #146] touch [Resident #163] 's chest just before	L 529		

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[pronoun] touched [pronoun] shoulder and asked[pronoun] for a cigarette ...Staff will continue to redirect [Resident 146] ... will remain on 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 CNA turned away from Resident #146 and was talking to 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 perform an 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 #146's chest, Resident #163 stated, 'I would like to do that, but didn't know anything about that incident.'

During a face-to-face interview on 02/27/23 at

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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 #146 in the first-floor dining room. As Resident #146 was walking past other residents, he was asking for a cigarette. When Resident #146 walked past Resident #163, [pronoun] asked [Resident #163] for a cigarette. Resident #163 said, 'No." and [Resident #146] touched [Resident # 163] on the shoulder. 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 the CNA 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 staff had knowledge and documentation of Resident #146's sexual behaviors towards other residents in the facility before the incident on 02/21/23 with Resident #164.

a.Although the facility had care plans in place to address Resident #146's sexual behaviors, there was no evidence that the interventions were revised or updated to manage the Resident's

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behavior. Notes from the psychiatrist and reports from staff showed that the Resident was continuously showing inappropriate sexual behaviors towards other residents.

b. Facility staff failed to document the names and room numbers of residents who were affected by Resident #146's behavior; and failed to assess how Resident #146's behavior impacted other residents.

c. Although the staff recorded that Resident #146 was being monitored hourly and 1:1, the Resident still sexually assaulted another Resident with facility staff present.

d. The Educator for the facility was not available for an interview, to discuss evidence of the education and training that the facility may have provided for staff on 1:1 monitoring of residents.

5. Facility staff failed to prevent physical abuse during a resident-to-resident altercation when Resident # 254 slapped his roommate, Resident #247.

A.Review of Resident #247's medical record revealed the Resident was admitted from a local hospital to the facility on 08/18/21 with diagnoses including: Quadriplegia, Respiratory Failure, Atrial Fibrillation, Epileptic Seizures, Anxiety and Depression.

Review of Resident #247's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 01/03/23 documented a Brief Interview for Mental Status (BIMS) summary score of "11," indicating that the Resident had moderately impaired cognition. In addition, the MDS assessment noted that the Resident

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L 529	Continued From page 140 required extensive assistance from staff for (assisted daily living skills (ADLs), required supervision from staff for locomotion in and off the unit, and used a wheelchair (electric) for mobility. Review of a Care Plan on 09/17/21 documented: "[Resident #247] behaviors demonstrating verbal abusive behaviors towards staff, use of profanity ... poor impulse control, hx (history) of telling untrue stories ...using power chair as a weapon ...Goal:[Resident #247] will have fewer episodes of behaviors ..... Interventions: Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document....Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation ...When resident becomes agitated intervene before agitation escalates; Guide away from source of distress ... " Review of a Care Plan on 02/14/22 documented: "[Resident #247] will be seeing the clinical personnel from Supportive Care for counseling and supportive therapy....Interventions [Resident #254] will see the clinical personnel from Supportive Care Services as needed. Revised on 06/0422." B. Review of Resident #254 medical record revealed that the Resident was admitted to the facility on 09/12/21 with diagnoses including Traumatic rupture of symphysis pubic (joint connecting the right and left pubic bones) sequela., Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Low Back Pain, and Generalized Muscle Weakness. Review of Resident #254's medical record revealed a Quarterly Minimum Data Set (MDS)	L 529		

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L 529	Continued From page 141 assessment dated 06/20/22 documented a Brief Interview for Mental Status (BIMS) summary score of "15," indicating that the Resident had intact cognition. In addition, the MDS assessment noted that the Resident required supervision from staff for locomotion in and off the unit, used a walker for mobility, and received antipsychotic medications. Review of a Care Plan on 09/14/21 documented: [Resident #254] has a behavior problem r/t (related to) refusing ...yelling on (at) staff, use of profanity ... Interventions" Monitor behavior episodes and attempt to determine underlying cause ..." Review of a Care Plan on 11/29/21 documented: [Resident #254] is at risk of trauma-related issues d/t (due to) being present when a physical abuse event occurred with another resident on 11/29/21. Goal: [Resident #254] will not have more than 1 episode of any trauma-related issues ...uses psychotropic medications r/t (related to) mood disorder and schizophrenia.....Interventions: Administer medications/treatments as ordered ...Offer support services per IDT members as needed. Review of a Care Plan on 02/14/22 documented: [Resident #254] will be seeing the clinical personnel from Supportive Care for counseling and supportive therapy....Interventions [Resident #254] will see the clinical personnel from Supportive Care Services as needed. A Psychiatric Progress Note dated 06/20/22 at 10:30 AM documented: "....Patient seen for monthly follow up. Requested to be seen for verbalizing depressed mood as per facility ...endorsed feeling sad and stated it was due to a	L 529		

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cousin [pronoun] lost last year February. "I even thought of hurting myself two weeks ago ...Currently denies SI/HI (Suicidal Ideation/Homicidal Ideation) and no intent ...Patient referred for 1:1 psychotherapy....."

Review of a facility-reported incident (FRI) (DC00010850) submitted on 07/08/22 at 3:34 PM documented "....On July 3, 2022, there was an alleged resident-to-resident physical altercation between roommates [Residents #247 and #254]. It was reported that [Resident #254]slapped [Resident #247] ...The residents were immediately separated.... [Resident #247] stated [Resident #254] took [pronoun] cigarette earlier in the day. When [Resident #247] asked for it,[Resident #254] slapped [Resident #247] .... [Resident #254] mentioned that [pronoun] slapped [Resident #247] because [pronoun] drove [pronoun] power chair into [pronoun] left ankle.....Witness statements indicated that residents were conversing near the nurse's station. The conversation began to escalate and [Resident #264] slapped [Resident #247]. .. Based on the full investigation and witness statements, the facility finds the alleged resident-to-resident physical altercation substantiated.....Metropolitan Police were called and interviewed both residents. There were no arrests and no charges filed. They were both referred to psychiatry. A room change was completed for [Resident #264]. Both residents were encouraged to stay away from each other ..."

Review of the medical records for Resident #247 and #256 showed documented evidence that both residents had histories of aggressive behaviors and altercations with other residents. There was no documented evidence that facility staff identified triggers or attempted to separate

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L 529	Continued From page 143 the residents once their conversation escalated. During a face-to-face interview on 03/10/23 at 9:37 AM, Employee #23, Unit Manager, stated that both residents (Residents #247 and #256) had aggressive behaviors but Resident #256 was the aggressor in the altercation in July. When asked what facility staff did to prevent the altercation between the two residents, Employee #23 stated that residents are encouraged to notify staff when they have problems with another resident. The Employee added that Resident #256 had been attending an outside behavior management program and both residents were referred to psych. During a face-to-face interview on 03/10/23 at 5:39 PM, with Employee #5 (Quality Nurse), when asked what interventions staff provide to prevent resident-to-resident altercations, the Employee responded that residents are kept apart, psychotropic medications are altered, smoking patio is monitored, residents are transferred to different units, and residents are educated to speak with staff and not to take matters into their own hands.	L 529		06/09/2023
L 539	3270.3a Nursing Facilities A current assessment of the resident's care needs and the kind of services and supports the resident will need upon discharge; This Statute is not met as evidenced by: Based on review of medical records, administrative records, facility documentation/policies, and family and staff interviews, for three (3) of 3 discharge residents, the facility's staff failed to ensure residents were	L 539		

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L 539	Continued From page 144 safely discharged as evident by not providing Residents #332, #585, and #586 with resident care needs including written instructions for discharge medications. Subsequently, Resident #332 was discharged home with Resident #27's Lisinopril (anti-hypertensive) medication and admitted to a local hospital's intensive care unit on a ventilator after she allegedly took Resident #27's Lisinopril. The findings included: 1. The facility's staff failed to ensure residents were safely discharged as evident by not providing Residents #332 with resident care needs including written instructions for discharge medications. Subsequently, Resident #332 was discharged home with Resident #27's Lisinopril (anti-hypertensive) medication and admitted to a local hospital's intensive care unit on a ventilator after she allegedly took Resident #27's Lisinopril. Review of Resident #332 ' s medical record revealed that the resident was admitted to the facility on 12/21/22 from a local hospital with history of multiple diagnoses including Hypertension, Heart Failure, and Pulmonary Embolism. Review of complaint received by the State Agency dated 01/26/23 (DC- 11567) documented, "On December 13, 2022 ... [Resident #332] was released from the nursing home on December 30 [2022], She was given medication (lisinopril) that had 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	L 539	1.R585, R586 were discharged on 1/11/23 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. 3.Licensed professional nursing staff. were in-service 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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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, I was told that it was my responsibility to check the medication and make sure it was not [Resident #322 ' s] and they were not accountable ... still remains in the hospital and was in a comatose state for at least a week ..."

Review of a policy titled, Discharge Summary dated 02/01/22, documented, "A final summary of the resident ' s status which includes ... for residents discharged to their home, the medical record should contain documentation that written discharge 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 ... In addition, the policy lacked documented evidence that the facility would dispense medication for residents to take home.

A Discharge Nursing Summary Note dated 12/30/22 at 12:59 PM documented, "Resident discharged home 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 and explained. She verbalized complete understanding ... She is self-responsible."

The facility ' s Discharge Planning/Summary

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L 539	Continued From page 146 Process dated 12/29/22 at 1:07 PM, documented, " ... 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 been provided for each of the medications being taken out of the facility. "Yes". However, continued review of the medical record lacked documented evidence of the printed/written directions provided to the resident or resident ' s family. The discharging nurse's statement dated 01/04/23 documented, " ... I explained to [resident and family] who were at the bedside ... the aftercare instructions which include (sp) the time and when to take each medication and treatment per doctor ' s orders... I then provided her with 2 copies of her discharge instructions and told her to go thoroughly through instructions, 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" During a telephone interview on 02/10/23 starting at 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. During a telephone interview on 02/10/23 at 5:17	L 539		

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L 539	Continued From page 147 PM, Employee #4 (LPN-Discharging Nurse) 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. And the only written instruction he provided for medication was a copy of the prescriptions." During a face-to-face interview on 02/10/23 starting at approximately 5:30 PM, Employee #3 (DON) stated that Employee #4 should have been provided the resident with written instruction on how to safely administer the prescribed discharge medications at home. Please cross refrence F624 2. The facility's staff failed to ensure residents were safely discharged as evident by not providing Resident #586 with resident care needs including written instructions for discharge medications. Resident #586 was admitted to the facility on 02/05/20 with multiple diagnoses that included: Metabolic Encephalopathy, Hyperlipidemia, Acute Kidney Failure, Fracture of Right Femur, and Cognitive Communication Deficit. Review of the resident ' s medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 11/8/22 which documented a Brief Interview for Mental Status summary score of "12" indicating the resident was cognitively intact. A Nursing Progress Note dated 12/27/22 at 9:30 AM documented, ""Resident went home with an	L 539		

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L 539	Continued From page 148 escort via Uber, a copy of discharge summary was handed to him with all his belongings ..." A Discharge Planning Summary/Process dated 12/27/22 at 1:24 PM documented," ...Resident is alert 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 that the resident was t provided written instructions on how 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 about the 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. taken blood pressure before taking blood pressure medication. 3. The facility's staff failed to ensure residents were safely discharged as evident by not providing Residents #585 with resident care needs including written instructions for discharge medications. Resident #585 was admitted to the facility on 12/01/22 with multiple diagnoses that included: Cognitive Communication Deficit, Cerebral Infarction, Dysphagia, Hypertensive Urgency, and Muscle Weakness.	L 539		

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L 539	Continued From page 149 Review of Resident #585 ' s medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 12/08/22 which documented a Brief Interview for Mental Status summary score of "03", indicating the resident was severely impaired. 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 the facility ...a) "Yes". A nursing progress note dated 01/11/23 at 4:32 PM documented, "Resident was discharged home this 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 that Resident #585 or the resident ' s representative was provided the resident 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 03:30 PM, Employee #3 (DON)was asked about the facility's policy pertaining to resident discharges, instructions, and medications. Employee #3 stated that the resident should	L 539		

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	HFD02-0031	A. BUILDING: _____ B. WING _____	C 03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 539	Continued From page 150 receive discharge instructions in writing which includes the medication list ..."	L 539		