DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING ______ B. WING ______	R-C 06/16/2023

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) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

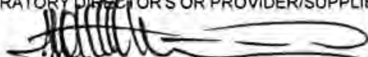
An onsite Revisit Survey was conducted at this facility from June 13 - 16, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 297 and the survey sample included 63 residents.

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.

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
DON - Director of Nursing
ED - Emergency Department

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: ADMINISTRATOR

(X6) DATE: 06/28/202

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

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{F 000}	Continued From page 1	{F 000}		

EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD - Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2 - Oxygen
PA - Physician's Assistant
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO - by mouth
POA - Power of Attorney

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{F 000}	Continued From page 2 POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	{F 000}		
{F 600} SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, for one (1) of 63 sampled residents, facility staff failed to protect and put in	{F 600}	1.R110 currently resides in the facility with no ill effects noted. R110 was assessed on 6/13/23 by a licensed nurse. R151 currently resides in the facility with no ill effects. R151 was assessed on 6/13/23 by Nurse practitioner. Resident #151 was compensated for funds which were misappropriated by Resident #110 on June 13, 2023, by the business office. Resident 151 already had a key issued for his bedside drawer. He was reminded on 6/13/23 on the importance of locking up his valuables. E3 (Director of Social Services) was educated on policy and procedure for reporting to state agency allegations of abuse on June 27, 2023 to include misappropriation of funds. 2. The DON or designee will review all grievances in the last 7 days to assure that any allegation of misappropriation of funds were reported to the state agency. All residents may be affected by this deficient practice. Any issues will be corrected immediately. 3. DON, nursing supervisors and social worker director will be educated by the Educator/ designee on policy and procedure for reporting requirements to the state agency for allegations of abuse which includes misappropriation of funds. 4. The DON or designee will audit all grievance daily x 5, weekly x3 then monthly x2 or until compliance is achieved to assure that any allegation of misappropriation of funds were reported to the state agency and interventions were put into place to prevent and correct any additional misappropriation. Any identified issues will be corrected. Results of the audits will be submitted to the QA and performance committee. 5. Date of compliance 07/06/2023	

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{F 600}	Continued From page 3	{F 600}		

place corrective actions to prevent Resident #151 from misappropriation of funds by Resident #110.

The findings included:

The facility's Plan of Corrections with a compliance date of 06/09/23 documented, "...The Clinical consultant or designee will provide education to all facility staff on policies and procedures for abuse prohibition ..."

Review of the facility policy "Abuse, Neglect and Exploitation" with a review date of 05/19/23 directed, " ...The facility will develop and implement written policies and procedures that prohibit and prevent abuse neglect and exploitation of residents and misappropriation of resident property ... Prevention of Abuse, neglect and exploitation ... identifying, correcting and intervening in situations in which abuse neglect exploitation and/or misappropriation of resident property is more likely to occur ... ongoing assessment, care planning for appropriate interventions and monitoring ...Protection of resident ... responding immediately to protect the alleged victim ... room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator ..."

Resident #110 was readmitted to the facility on 06/16/22 with multiple diagnoses that included but was not limited to Schizophrenia and Parkinson's Disease.

Review of Resident #110's medical record revealed a face sheet that showed the resident resided in room 127 bed B since 08/19/22.

Progress notes dated from 10/10/22 to 12/10/22

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{F 600}	Continued From page 4	{F 600}		

showed that the facility documented two (2) incidents (on 10/18/22 and 12/03/22) where Resident #110 had taken money from other residnents of the facility.

A Quarterly Minimum Data Set (MDS) assessment dated 04/13/23 showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; no hallucinations or delusions; wandering behaviors not exhibited; required supervision for locomotion on and off the unit; and no functional limitations in range of motion.

Resident #151 was admitted to the facility on 08/06/18 with multiple diagnoses that included: Cognitive Communication Deficit, Acquired Absence of Left Above the Knee, and Muscle Weakness.

Resident #151's medical record revealed a face sheet that showed the resident resided in room 109 bed A since 03/05/23.

A Quarterly Minimum Data Set assessment dated 05/24/23 showed facility staff coded Resident #151 as having clear speech; makes self understood, adequate vision with use of corrective lenses; A Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; no hallucinations or delusions; required extensive assistance with two person physical assist for bed mobility; functional limitation in range of motion on one side for upper and lower extremity and used a wheelchair for mobility.

A "Resident Fund Management Service" form documented, " ... [Resident #151] ... 60.00

{F 600} Continued From page 5 {F 600}

(dollars) amount withdrawal ... Jun 8 12:41 PM (June 8, 2023)."

A 06/09/23 at 2:18 PM nurses note documented, "[Resident #151] informed one of the GNA (Graduate Nurse Aide) that [Resident #110] came into his room and removed his wallet from his socks, RN (Registered Nurse) approached resident and asked if she took [Resident #151] wallet, resident denies entering resident room and taking his wallet. Nurse caring for [Resident #151] informed, and grievance form filled."

A "Grievance Form" dated 06/09/23 documented, "... [Resident #151] reported that a resident (Resident #110) did take his money from his room. Statements have been collected from staff ... Will review to see what are the necessary next steps..."

It should be noted that as of 06/13/23, four days after the incident, facility staff failed to report this incident to the State Agency and and put in place any corrective actions to prevent or protect Resident #151 from Resident #110, who has a documented history of misappropriating resident's funds.

During a face-to-face interview on 06/13/23 at 11:49 AM with Employee #3 (Director of Social Services) stated that when she was made aware of the incident (on 06/09/23), she gathered statements from Resident #151, the staff on the unit and the bank and that Resident #110 refused to give a written or any kind of statement. When asked why this incident was not reported to the State Agency, the employee stated that she was not clear on what the facility's process is for reporting. When asked if this incident would fall

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{F 600}	Continued From page 6	{F 600}		

under misappropriation of resident funds, Employee #3 stated that she could not affirm or deny that because she was not familiar with the facility's policy. When asked what preventative measures were put in place to prevent Resident #110 from touching and taking Resident #151's property, Employee #3 stated "I spoke to the educator to provide education to staff to increase surveillance of Resident #110. I gave my report to the Administrator for review on Friday (06/09/23) and am waiting on what the next steps are."

During an observation and interview of Resident #151 on 06/13/23 at 12:12 PM, the resident was noted to be in room 109 bed A (closest to the door) lying in bed. The resident had a lock box on his bedside drawer with the key on a chain that was around his neck. Regarding the allegation, Resident #151 stated that he withdrew sixty dollars from the bank yesterday (06/08/23) and had it in his wallet, which was placed inside his sock, on his right foot. Resident #151 further stated that the next day (06/09/23), while he was lying in bed, the lady (Resident #110) came inside his room, pulled down the bed covers, went to where he kept his wallet and took it. He screamed for help but by the time staff came, the lady had already left. Resident #151 stated that he doesn't remember her name but that she stays across the hall. When asked how "the lady" knew where he kept his money, Resident #151 stated, "I sometimes would ask her to go to the vending machine for me." The resident then shook his right foot, where he was wearing a blue sock, and stated, "That's where I like to keep my money." The surveyor heard what sounded like multiple coins. Upon exit of Resident #151's room (room 109), room 127 was observed to be across the hall.

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{F 600} Continued From page 7 {F 600}

During a face-to-face interview conducted on 06/13/23 at 12:17 PM with Employee #20 (CNA-present on the day of the incident) stated, "[Resident #151's] assigned CNA came to me and told me that [Resident #151] said [Resident #110] went into his room and took his money and by the time someone came, she was already gone. Myself, the other CNA and the nurse assigned to [Resident #151] went to [Resident #110's] room and asked about the wallet. She said she did not have it, went inside her bathroom and locked the door. We waited for her to come out. When she came out, that's when we saw a wallet in the trash, there was nothing else in it, no money. I asked her where it (the wallet) came from. She said she doesn't know. The nurse then took the wallet to [Resident #151] and he confirmed that it was his wallet that was taken from him. When she (Resident #110) was asked about the money again, she said 'I gave the money to my friend upstairs' but would not say the name of the person." It should be noted that this employee provided a written statement dated 06/09/23 to the facility's administration as part of the grievance documents.

On 06/13/23 at approximately 12:40 PM, Resident #110 was observed in the resident lounge area on the first floor. When asked about the alleged incident, she stated that she had nothing to say.

During a face-to-face interview on 06/13/23 at 1:00 PM Employee #1 (Administrator), stated that he was aware of the grievance but had not yet reviewed it nor was he aware that this incident had not been reported to the State Agency. When asked if he was aware that no preventative

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{F 600}	Continued From page 8 measures were taken to correct and intervene to prevent the likelihood of misappropriation of Resident #151's property from reoccurring, Employee #1 was not able to provide an answer. During a face-to-face interview on 06/14/23 at 2:20 PM with Employee #21 (Educator/Former Director of Nursing) acknowledged that facility staff failed to implement any new care interventions that addressed Resident #110's behavior of misappropriating other resident's funds and failed to put in place interventions to protect Resident #151 after the 06/09/23 incident. Cross Reference 22B - Sec. 3232.2	{F 600}		
{F 607} SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	{F 607}	1.R110 currently resides in the facility with no ill effects. R110 was assessed on 6/13/23 by licensed nurse. R151 currently resides in the facility with no ill effects. R151 was assessed on 6/13/23 by Nurse practitioner. R110's plan of care was revised on 6/23/23, seen by psych for behavior management on 6/26/23. R151 was provided emotional support and funds were replaced. 2. Progress notes of all current residents in the facility for 24hrs will be reviewed by the DON/designee beginning June 27 through June 28, 2023, to evaluate any reported incidents of misappropriation of resident funds. All issues noted will be corrected immediately. All residents may be affected by this deficient practice. Findings will be corrected immediately. 3. Facility Staff (DON, nursing supervisors and social worker director) will be educated by the Educator/Designee on implementing policies and procedures for abuse/neglect allegations in regards to reporting to DOH including misappropriation of funds. 4. Audits will be completed by the DON/Designee of progress notes and grievance forms to assure that staff has implemented policies and procedures for abuse/neglect allegations in regards to reporting abuse including misappropriation of funds. Audits will be conducted weekly times 4 then monthly times 3 or until compliance is reached. Any identified issues will be corrected. Results of the audits will be submitted to the QA and performance committee. 5. Date of compliance 07/06/2023	

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{F 607}	Continued From page 9	{F 607}		

but are not limited to the following elements.

§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.

§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, facility staff failed to implement their Abuse, Neglect and Exploitation policy for 1 of 63 sampled residents. (Resident #15)

The findings included:

The facility's Plan of Corrections with a compliance date of 06/09/23 documented, "...The Clinical consultant or designee will provide education to all facility staff on policies and procedures for abuse prohibition ..."

Review of the facility policy "Abuse, Neglect and Exploitation" with a review date of 05/19/23 directed, " ...The facility will develop and implement written policies and procedures that prohibit and prevent abuse neglect and exploitation of residents and misappropriation of resident property ... Prevention of Abuse, neglect and exploitation ... identifying, correcting and intervening in situations in which abuse neglect exploitation and/or misappropriation of resident property is more likely to occur ... ongoing assessment, care planning for appropriate interventions and monitoring ...Protection of resident ... responding immediately to protect the alleged victim ... room or staffing changes, if

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{F 607}	Continued From page 10 necessary, to protect the resident(s) from the alleged perpetrator ..." Resident #110 was readmitted to the facility on 06/16/22 with multiple diagnoses that included but was not limited to Schizophrenia and Parkinson's Disease. Review of Resident #110's medical record revealed a face sheet that showed the resident resided in room 127 bed B since 08/19/22. Progress notes dated from 10/10/22 to 12/10/22 showed that the facility documented two (2) incidents (on 10/18/22 and 12/03/22) where Resident #110 had taken money from other residnents of the facility. A Quarterly Minimum Data Set (MDS) assessment dated 04/13/23 showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; no hallucinations or delusions; wandering behaviors not exhibited; required supervision for locomotion on and off the unit; and no functional limitations in range of motion. Resident #151 was admitted to the facility on 08/06/18 with multiple diagnoses that included: Cognitive Communication Deficit, Acquired Absence of Left Above the Knee, and Muscle Weakness. Resident #151's medical record revealed a face sheet that showed the resident resided in room 109 bed A since 03/05/23. A Quarterly Minimum Data Set assessment dated 05/24/23 showed facility staff coded Resident	{F 607}		

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{F 607}	Continued From page 11	{F 607}		

#151 as having clear speech; makes self understood, adequate vision with use of corrective lenses; A Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; no hallucinations or delusions; required extensive assistance with two person physical assist for bed mobility; functional limitation in range of motion on one side for upper and lower extremity and used a wheelchair for mobility.

A "Resident Fund Management Service" form documented, " ... [Resident #151] ... 60.00 (dollars) amount withdrawal ... Jun 8 12:41 PM (June 8, 2023)."

A 06/09/23 at 2:18 PM nurses note documented, "[Resident #151] informed one of the GNA (Graduate Nurse Aide) that [Resident #110] came into his room and removed his wallet from his socks, RN (Registered Nurse) approached resident and asked if she took [Resident #151] wallet, resident denies entering resident room and taking his wallet. Nurse caring for [Resident #151] informed, and grievance form filled."

A "Grievance Form" dated 06/09/23 documented, "... [Resident #151] reported that a resident (Resident #110) did take his money from his room. Statements have been collected from staff ... Will review to see what are the necessary next steps..."

It should be noted that as of 06/13/23, four days after the incident, facility staff failed to report this incident to the State Agency and and put in place any corrective actions to prevent or protect Resident #151 from Resident #110, who has a documented history of misappropriating resident's

{F 607} Continued From page 12 {F 607}

funds.

During a face-to-face interview on 06/13/23 at 11:49 AM with Employee #3 (Director of Social Services) stated that when she was made aware of the incident (on 06/09/23), she gathered statements from Resident #151, the staff on the unit and the bank and that Resident #110 refused to give a written or any kind of statement. When asked why this incident was not reported to the State Agency, the employee stated that she was not clear on what the facility's process is for reporting. When asked if this incident would fall under misappropriation of resident funds, Employee #3 stated that she could not affirm or deny that because she was not familiar with the facility's policy. When asked what preventative measures were put in place to prevent Resident #110 from touching and taking Resident #151's property, Employee #3 stated "I spoke to the educator to provide education to staff to increase surveillance of Resident #110. I gave my report to the Administrator for review on Friday (06/09/23) and am waiting on what the next steps are."

During an observation and interview of Resident #151 on 06/13/23 at 12:12 PM, the resident was noted to be in room 109 bed A (closest to the door) lying in bed. The resident had a lock box on his bedside drawer with the key on a chain that was around his neck. Regarding the allegation, Resident #151 stated that he withdrew sixty dollars from the bank yesterday (06/08/23) and had it in his wallet, which was placed inside his sock, on his right foot. Resident #151 further stated that the next day (06/09/23), while he was lying in bed, the lady (Resident #110) came inside his room, pulled down the bed covers, went to where he kept his wallet and took it. He screamed

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	095022	A. BUILDING ______ B. WING ______	R-C 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 607}	Continued From page 13 for help but by the time staff came, the lady had already left. Resident #151 stated that he doesn't remember her name but that she stays across the hall. When asked how "the lady" knew where he kept his money, Resident #151 stated, "I sometimes would ask her to go to the vending machine for me." The resident then shook his right foot, where he was wearing a blue sock, and stated, "That's where I like to keep my money." The surveyor heard what sounded like multiple coins. Upon exit of Resident #151's room (room 109), room 127 was observed to be across the hall. During a face-to-face interview conducted on 06/13/23 at 12:17 PM with Employee #20 (CNA-present on the day of the incident) stated, "[Resident #151's] assigned CNA came to me and told me that [Resident #151] said [Resident #110] went into his room and took his money and by the time someone came, she was already gone. Myself, the other CNA and the nurse assigned to [Resident #151] went to [Resident #110's] room and asked about the wallet. She said she did not have it, went inside her bathroom and locked the door. We waited for her to come out. When she came out, that's when we saw a wallet in the trash, there was nothing else in it, no money. I asked her where it (the wallet) came from. She said she doesn't know. The nurse then took the wallet to [Resident #151] and he confirmed that it was his wallet that was taken from him. When she (Resident #110) was asked about the money again, she said 'I gave the money to my friend upstairs' but would not say the name of the person." It should be noted that this employee provided a written statement dated 06/09/23 to the facility's administration as part of the grievance documents.	{F 607}		

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{F 607}	Continued From page 14 On 06/13/23 at approximately 12:40 PM, Resident #110 was observed in the resident lounge area on the first floor. When asked about the alleged incident, she stated that she had nothing to say. During a face-to-face interview on 06/13/23 at 1:00 PM Employee #1 (Administrator), stated that he was aware of the grievance but had not yet reviewed it nor was he aware that this incident had not been reported to the State Agency. When asked if he was aware that no preventative measures were taken to correct and intervene to prevent the likelihood of misappropriation of Resident #151's property from reoccurring, Employee #1 was not able to provide an answer. During a face-to-face interview on 06/14/23 at 2:20 PM with Employee #21 (Educator/Former Director of Nursing) acknowledged that facility staff failed to implement any new care interventions that addressed Resident #110's behavior of misappropriating other resident's funds and failed to put in place interventions to protect Resident #151 after the 06/09/23 incident. Cross Reference 22B - Sec. 3232.2	{F 607}		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	{F 609}	1. The facility reported the misappropriation of funds by R110 to the State Agency on June 13, 2023. Employee #1 (Administrator) was educated by Regional Director of Operations/designee on June 27, 2023, related to timely reviewing any grievances of misappropriation of funds in order to assure that reporting to state agency within the timeframe. 2. Grievances in the last 7 days will be reviewed by the DON/designee beginning June 27, 2023, to assure that any allegations of misappropriation of funds were reported to the state agency. All residents may be affected by this deficient practice. Findings will be corrected immediately. 3. Administrator/DON/QA consultant /Director of Social work/Nursing supervisors will be educated by the Regional Director of Operations/Designee on assuring that any allegations of misappropriation of funds are reported in the	

required timeframe to the state agency.
4. Audits will be completed by the DON/Designee of grievance forms in the last 7 days to assure that any allegations of misappropriation of funds are reported within the required timeframe to the state agency. Audits will be completed weekly times 4 then monthly times 3 or until compliance is achieved. Any identified issues will be corrected. Results of the audits will be submitted to the QA and performance committee.
5. Date of compliance 07/06/2023

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{F 609}	Continued From page 15 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an incident of misappropriation of funds to the State Agency within the required time frame. This evident for 1 of 63 residents sampled. (Resident #110) The findings included: The facility's Plan of Corrections with a compliance date of 06/09/23 documented, "...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	{F 609}		

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{F 609}	Continued From page 16 Administrator, state agency and required agencies within specified timeframes...The Director of Nursing/designee will review incidents of unknown source to assure that the incident was reported to the State agency per protocol.." Resident #151 was admitted to the facility on 08/06/18 with multiple diagnoses that included: Cognitive Communication Deficit, Acquired Absence of Left Above the Knee, and Muscle Weakness. A Quarterly Minimum Data Set dated 05/24/23 showed facility staff coded: clear speech; makes self understood, adequate vision with use of corrective lenses; A Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; no hallucinations or delusions; required extensive assistance with two person physical assist for bed mobility; functional limitation in range of motion on one side for upper and lower extremity and used a wheelchair for mobility. A "Grievance Form" dated 06/09/23 documented, "... [Resident #151] reported that a resident (Resident #110) did take his money from his room. Statements have been collected from staff ... Will review to see what are the necessary next steps..." A 06/09/23 at 2:18 PM nurses note documented, "[Resident #151] informed one of the GNA (Graduate Nurse Aide) that [Resident #110] came into his room and removed his wallet from his socks, RN (Registered Nurse) approached resident and asked if she took [Resident #151] wallet, resident denies entering resident room and taking his wallet. Nurse caring for [Resident	{F 609}		

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{F 609}	Continued From page 17 #151] informed, and grievance form filled." During a face-to-face interview on 06/13/23 at 11:49 AM with Employee #3 (Director of Social Services) stated that when she was made aware of the incident (on 06/09/23), she gathered statements from Resident #151, the staff on the unit and the bank and that Resident #110 refused to give a written or any kind of statement. When asked why this incident was not reported to the State Agency, the employee stated that she was not clear on what the facility's process is for reporting. When asked if this incident would fall under misappropriation of resident funds, Employee #3 stated that she could not affirm or deny that because she was not familiar with the facility's policy. During a face-to-face interview on 06/13/23 at 1:00 PM Employee #1 (Administrator), stated that he was aware of the grievance but had not yet reviewed it nor was he aware that this incident had not been reported to the State Agency. Cross Reference 22B DCMR Sec. 3232.4	{F 609}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	{F 656}		

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{F 656}	Continued From page 18 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for two (2) of 63 sampled residents, facility staff failed to develop and implement a comprehensive	{F 656}	R110 currently resides in the facility with no ill effects noted. R110 was assessed on 6/13/23 by a licensed nurse. R325 was discharged on 6/13/2023 R110 comprehensive care plan interventions was developed on June 9, 2023, to address the behavior of willfully misappropriating other resident's funds; Resident #325's care plan was updated and implemented to include aspiration precautions on June 12, 2023. 2. Physician orders for aspiration precautions will be reviewed by the DON/Designee on June 27, 2023, to assure care plans have documented evidence of goals and interventions to address aspiration precautions. -Progress notes of all current residents in the facility for 24hrs will be reviewed by the DON/designee beginning June 27 through June 28, 2023, to evaluate any reported incidents of misappropriation of resident funds All residents may be affected by the deficient practice associated with misappropriation of funds. All residents who are at risk for aspiration may be affected by this deficient practice. Findings will be corrected immediately. 3. Licensed nurses, dietician and therapy staff (speech therapist) will be educated by the Nurse educator/designee on the importance of assuring that residents with physician orders for aspiration precautions are addressed on the comprehensive care plan - Facility Staff (unit managers, social work staff and activity staff) will be educated by the Educator/Designee on assuring that care plan addresses preventative measures to intervene in order to prevent the likely hood of misappropriation of funds. 4. Audits will be conducted by the DON/Designee to ensure there is a comprehensive care plan for residents with physician orders for aspiration precautions. -Audits will be conducted by DON/designee of grievance forms to assure that care plan addresses preventative measures to intervene in order to prevent the likely hood of misappropriation of funds. Audits will be completed weekly times 4 then monthly times 3 or until compliance is achieved. Any identified issues will be corrected. Results of the audits will be submitted to the QA and performance committee. 5. Date of compliance 07/06/2023	

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{F 656}	Continued From page 19 person-centered care plan to address 1. Resident #110's behavior of willfully misappropriating other resident's funds (Resident #151), and 2. Resident #325's physician's order for aspiration precautions. (Residents' #110 and #325). The findings included: The facility's Plan of Corrections with a compliance date of 06/09/23 documented, "...The Clinical consultant or designee will provide education to all facility staff on policies and procedures for abuse prohibition ..." Review of the facility policy "Abuse, Neglect and Exploitation" with a review date of 05/19/23 directed, " ...The facility will develop and implement written policies and procedures that prohibit and prevent abuse neglect and exploitation of residents and misappropriation of resident property ... Prevention of Abuse, neglect and exploitation ... identifying, correcting and intervening in situations in which abuse neglect exploitation and/or misappropriation of resident property is more likely to occur ... ongoing assessment, care planning for appropriate interventions and monitoring ...Protection of resident ... responding immediately to protect the alleged victim ... room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator ..." Resident #110 was readmitted to the facility on 06/16/22 with multiple diagnoses that included but was not limited to Schizophrenia and Parkinson's Disease. Review of Resident #110's medical record revealed a face sheet that showed the resident	{F 656}		

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{F 656}	Continued From page 20	{F 656}		

resided in room 127 bed B since 08/19/22.

Progress notes dated from 10/10/22 to 12/10/22 showed that the facility documented two (2) incidents (on 10/18/22 and 12/03/22) where Resident #110 had taken money from other residnents of the facility.

A Quarterly Minimum Data Set (MDS) assessment dated 04/13/23 showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; no hallucinations or delusions; wandering behaviors not exhibited; required supervision for locomotion on and off the unit; and no functional limitations in range of motion.

A 06/09/23 at 2:18 PM nurses note documented, "[Resident #151] informed one of the GNA (Graduate Nurse Aide) that [Resident #110] came into his room and removed his wallet from his socks, RN (Registered Nurse) approached resident and asked if she took [Resident #151] wallet, resident denies entering resident room and taking his wallet. Nurse caring for [Resident #151] informed, and grievance form filled."

A "Grievance Form" dated 06/09/23 documented, "... [Resident #151] reported that a resident (Resident #110) did take his money from his room. Statements have been collected from staff ... Will review to see what are the necessary next steps..."

It should be noted that as of 06/13/23, four days after the incident, facility staff failed to put in place any corrective actions to prevent or protect Resident #151 from Resident #110, who has a documented history of misappropriating resident's

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{F 656}	Continued From page 21	{F 656}		

funds.

During a face-to-face interview on 06/13/23 at 11:49 AM with Employee #3 (Director of Social Services) regarding any preventative measures put into place to prevent Resident #110 from touching and taking Resident #151's property, Employee #3 stated "I spoke to the educator to provide education to staff to increase surveillance of Resident #110. I gave my report to the Administrator for review on Friday (06/09/23) and am waiting on what the next steps are."

On 06/13/23 at approximately 12:40 PM, Resident #110 was observed in the resident lounge area on the first floor. When asked about the alleged incident, she stated that she had nothing to say.

During a face-to-face interview on 06/13/23 at 1:00 PM Employee #1 (Administrator), when asked if he was aware that no preventative measures were taken to correct and intervene to prevent the likelihood of misappropriation of Resident #151's property from reoccurring, Employee #1 was not able to provide an answer.

During a face-to-face interview on 06/14/23 at 2:20 PM with Employee #21 (Educator/Former Director of Nursing) acknowledged that facility staff failed to implement any new care interventions that addressed Resident #110's behavior of misappropriating other resident's funds and failed to put in place interventions to protect Resident #151 after the 06/09/23 incident.

2. The facilty staff failed to develop a comprehensive care plan to address Resident

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{F 656}	Continued From page 22 #325's physician order for aspiration precautions. Resident #325 was admitted to the facility on 12/30/22. The resident had a history of multiple diagnoses, including Dysphagia Oropharyngeal Phase, Transient Ischemic Attack, Cerebral Infarction without Residual Deficits, and Muscle Weakness. A review of a physician order dated 12/30/22, directed, "Aspiration Precautions." A review of the resident's care plans with an initial date of 12/30/22 lacked documented evidence of goals and interventions to address the physician order for aspiration precautions. A review of a quarterly Minimum Data Set dated 04/07/23, documented the resident had a Brief Interview for Mental Status summary score of "09" indicating the resident had a slightly impaired cognitive status. The resident was also coded for requiring the supervision and set-up from one staff person for eating. In addition, the resident was not coded for receiving rehabilitation services to include speech therapy. During a face-to-face interview on 06/13/23 at 9:30 AM, Employee #7 (Interim Unit Manager/ADON) stated that the resident did not have a care plan for aspiration precautions, but she would develop one immediately. Cross-reference 483.25 Quality of Care F689-Free of Accident Hazards. Cross Reference 22B DCMR - Sec. 3210.4.	{F 656}		
{F 684} SS=D	Quality of Care	{F 684}		

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{F 684}	Continued From page 23 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, for one (1) of 63 sampled residents, the facility staff failed to follow a physician's order for a resident on strict aspiration precautions. (Resident #135) The findings included: A review of Resident #135's medical record revealed that the Resident was admitted to the facility on 08/07/17 with diagnoses including Dysphagia, Type 2 Diabetes, Encephalopathy, Dementia, and Need for Assistance with Personal Care. The medical record showed a physician's order dated 04/04/23 at 1:49 AM documenting, "Regular diet. Mechanical Soft texture, Thin consistency, No Straws, strict aspiration precaution." A care plan revised on 05/18/23 documented [Resident #135] with low BMI (body mass index), mech (mechanical) soft diet, and altered skin integrity. Goal: Resident will tolerate modified diet safely x 90 days ...Interventions/Tasks: Diet:	{F 684}	1.R135 currently resides in the facility with no ill effects noted. R135 was assessed on 6/14/23 by MD. R135 straws found in room were discarded by the nurse manager on June 13, 2023. 2. Residents with orders for "no straws" were reviewed by the Dietician on June 16, 2023. Staffed assured that resident's with "no straw" rooms were checked to ensure meal trays nor bedside had straws available. All residents with a "no straw" or may be affected by this deficient practice. Findings will be corrected immediately. 3. Nursing/dietary/activities staff will be educated by the Educator/Designee to assure that residents with orders for "no straws" are not provided straws on meal trays or at bedside. 4. Audits of meal trays and resident rooms will be done by the DON/Designee to assure that residents with Physician orders for "no straws "are not provided straws and straws not present at bedside. Audits will be completed weekly times 4 then monthly times 3 or until compliance is achieved. Results of the audits will be submitted to the QA and performance committee. 5. Date of compliance 07/06/2023	

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

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{F 684}	Continued From page 24	{F 684}		

Mech Soft (no straws) ..."

An Annual Minimum Data Set Assessment dated 05/22//23 documented that the Resident was cognitively intact, required extensive assistance with eating, and was on a mechanically-altered diet.

A report entitled "Diet Type Report" dated 06/15/23 at 5:54 AM, documented: " ...Name: [Name of Resident]; Location: [Room of Resident]; Diet Type: Regular; Diet Texture: Mechanical Soft Diet; Fluid Consistency: Regular (Thin); Additional Directions: No Straws, strict aspiration precautions."

During a tour and observation of Unit 2 South on 06/15/23 at approximately 11:30 AM, Resident #135 was lying in bed. There was one straw in a wrapper on the floor and another opened straw sitting on the Resident's bedside table, along with a cup half filled with apple juice.

During a second observation on 06/15/23 at approximately 11:33 AM, Employee #8 (certified nursing assistant-CNA assigned to Resident #135) and the surveyor observed Resident in the room, lying in the bed. The straws were still in the Resident's room. There was one straw in a wrapper on the floor and another opened straw sitting on the Resident's bedside table, along with a cup half filled with apple juice.

A copy of the lunch meal tray ticket on 06/15/23 documented "No Straws."

During a face-to-face interview with Resident #135 on 06/15/23 at approximately 11:30 AM, the Resident stated that she did not remember who

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{F 684} Continued From page 25

put the straws there. The Resident also reported that she had to tell the CNA that she couldn't have straws.

During a face-to-face interview on 06/15/23 at approximately 11:33 AM, Employee #8 (CNA caring for Resident #135) stated, "When I came in at approximately 9:00 AM. I provided ADL (assisted daily living) care for the Resident. Nothing was on the Resident's bedside table because I had cleaned it. I did not put the straws there. Maybe one of the other CNAs or somebody who handed out snacks did."

During a face-to-face interview on 06/15/23 at approximately 11:50 AM, Employee #7 (2 South Unit Manager) stated that she told Employee #8, when the Employee reported to the unit, that Resident #135 does not get straws. Employee #7 then stated that she would initiate an investigation and get statements from staff who worked with Resident #135 that morning.

During a telephone interview on 06/15/23 at 2:02 PM, when asked how she ensures that residents are getting the correct diet and items on meal trays, Employee #9 (CNA), stated, "I checked the ticket and made sure what's on the ticket is what is on the plate. If it's a new resident, I will ask the Nurse. Nurses and CNAs are supposed to check the meal tickets before handing out trays. I have worked with Resident #135, who uses no straws. The Resident has a regular diet. I'm unsure if no straws are on her meal tickets, but if I saw them, I would take them out before entering her room.

A "Documentation Survey Report" report for June 2023 showed that from 06/09/23 to 06/16/23, Certified Nurses Assistants(CNAs) assisted

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{F 684}	Continued From page 26 Resident #135 with eating, drinking, and obtaining snacks. Of note, Employee #8 was noted as assisting Resident #135 with eating and fluid intake at 9:00 AM. During a face-to-face interview on 06/16/23 at approximately 11:00 AM, Employee #11 stated that she was the day shift CNA usually assigned to Resident #135 but had not worked on 06/15/23 when the incident occurred. The Employee reported that the Charge Nurse huddles with CNA's to give reports on the residents, including their diets. The Employee added, "I have received training on resident meal trays and resident diets. If I saw straws in the Resident's room, I would take the straws out, inform the Charge Nurse and remind the other CNAs that the Resident is not supposed to have straws."	{F 684}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, for 2 (two) of 63 sampled residents, facility staff failed to provide an environment for residents that was free of accident hazards and failed to ensure that residents received adequate supervision to prevent accidents, as evidenced by 1. failing to safely feed a resident, who had	{F 689}		

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ordered aspiration precautions, and 2. failing to remove straws from the meal tray of a resident who was on aspiration precautions. (Residents #325 and #135)

The findings included:

1. Resident #325 was admitted to the facility on 12/30/22. The resident had a history of multiple diagnoses, including Dysphagia Oropharyngeal Phase, Transient Ischemic Attack, Cerebral Infarction without Residual Deficits, and Muscle Weakness.

A review of Resident #325's medical record showed a review of a physician order dated 12/30/22, directed, "Aspiration Precautions."

A review of the resident's care plans with an initial date of 12/30/22 lacked documented evidence of goals and interventions to address the physician order for aspiration precautions.

According to the National Institute of Health, in an article titled, Aspiration Precautions (Nursing) with a revised date of 03/16/23 documented, "Patients at high risk for aspiration should have precautions put in place to reduce the risk. These precautions are dependent on the predisposing risk factors for any individual ... Keep head of bed elevated ..." (https://www.ncbi.nlm.nih.gov/books/NBK568750/)

A review of a quarterly Minimum Data Set dated 04/07/23, documented the resident had a Brief Interview for Mental Status summary score of "09" indicating the resident had a slightly impaired cognitive status. The resident was also coded for requiring the supervision and set-up from one

{F 689}

1.R325 was discharged on 6/13/2023 and had no ill effects from the incident.
R135 currently resides in the facility with no ill effects noted. R135 was assessed on 6/14/23 by MD.
E17 was educated by the Educator on June 13, 2023, on after care (for mouth care), positioning of residents that are being fed that are on aspiration precautions; E8 was educated by the Educator on June 13, 2023, to assure that residents with "no straws" order has no straws at bedside and plan of care for aspiration precautions.

2. Observation of staff feeding residents with orders for "aspiration precautions" will be done by the Educator/Designee to assure positioning of resident is appropriate and that after care (mouth care) is provided to residents; Rounds of resident rooms by DON/designee during mealtimes and snack times will be conducted to assure that residents with orders for "no straws" will not be provided straws nor have straws present at bedside. R135 family was educated on 6/28/23 not to provide straws to the resident. All residents at risk for aspiration may be affected by this deficient practice.

3. Nursing staff (CNAs and licensed nurses) will be educated by the Educator/Designee to assure that residents on aspiration precautions are positioned appropriately during feeding and that after care (mouth care) is provided after feeding. Licensed nurses and CNAs will be educated by the Educator/Designee to assure that residents with orders for "no straws" are not provided straws nor present at bedside.
4. Audit of staff feeding residents with orders for aspiration precautions will be done by the Educator/Designee to assure that HOB is positioned appropriately and that after care (mouth care) is provided; Audit of resident rooms will be done by DON/Designee during meal times and snack times to assure that residents with orders for "no straws" are not provided straws nor straws present at bedside.
Audits will be completed weekly x4 then monthly times 3 or until compliance is achieved. Results of the audits will be submitted to the QA and performance committee.
5. Date of compliance 07/06/2023

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{F 689}	Continued From page 28 staff person for eating. In addition, the resident was not coded for receiving rehabilitation services to include speech therapy. A review of the facility's "Feeding Policy" with a review date of 05/23/23 lacked documented evidence of how staff where to position residents' before and after feeding. In addition, the policy revealed there were no after care procedures for staff to follow after feeding residents. A review of a nurse practitioner's progress note dated 06/12/23 at 6:17 PM documented, "Was asked to see pt [patient] for change in condition ... Staff reprots [reports]that he does eat most of his eals [meals] but has to be fed now. I offered him a cookie, he took it, but couldn't bring it to his mouth ... Will f/u [follow-up] Cont., [continue] to monitor. An observation of the resident's room on 06/13/23 at 9:10 AM revealed Resident #325 was awake, lying in bed in a supine (flat on back) position. He was also noted with food particles (eggs) in his mouth that he was chewing. However, he didn't appear to be in distress to include shortness of breath, coughing, or excessive saliva. The surveyor immediately called Employees #17 (CNA) and #18 (LPN) to the resident's bedside to observe Resident #325. Employee #18 (LPN) raised the resident's head-of-bed to a 90-degree angle and offered the resident some milk that was sitting on the bedside table. After drinking milk, the resident's mouth appeared to be free of food. An offer letter signed by the employee on 02/20/23 for a position as a Certified Nursing Assistant was noted in the administrative record.	{F 689}		

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The job functions included "Food Service Functions ...assist with feeding as indicated ...perform after meal care (i.e. ...brush teeth) ..." The documented indicated a start date of 3/22/23.

The facility's teaching tool titled, "Aspiration Precautions" that documented, " ...Have the resident sit up at 90-degree angle in bed or chair for meals. Stay up 30 minutes after meals. Then 45-degree angle at all times if possible ...have the drink water with meals. Water will help rinse food out of the mouth. This will decrease the risk that food will move into the airway ..."

A Clinical Skills Checklist and Competency Evaluation, titled, "Feeds Resident Who Cannot Feed Self" for Employee #17 (CNA) which documented, "At the end of meal, staff cleans resident's mouth and hands ...leave resident in upright sitting position (75-90 degrees) ..." The checklist was signed by Employee #19 (Staff Development/RN) on 03/28/23 indicating that Employee #17 was observed to be competent with feeding residents.

A quiz titled, "Aspiration Precautions" that Employee #17 (CNA) scored 100%, was also noted however it the quiz was undated so it could not be determined when the employee took the test.

During a face-to-face interview on 06/13/22 at 9:12 AM, Employee#17 (CNA) stated, "I laid him flat because I needed help pulling him up in the bed. I called the nurse (Employee#18, LPN) but he didn't come. The resident didn't have food in his mouth when I laid him flat. I fed him about 20 minutes ago." Employee #17 said that she

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{F 689}	Continued From page 30	{F 689}		

received in-service training on feeding residents and aspiration precautions but could not recall what was taught or the date. The employee also stated that the resident fed himself until "last Friday" (06/09/23). When asked, why did she lay the resident flat if the nurse didn't come to help reposition the resident, Employee #17 did not provide an answer.

During a face-to-face interview on 06/13/23 at 9:15 AM, Employee #18 (LPN) stated that he could not recall Employee# 17 (CNA) calling him for assistance to reposition Resident #325. Employee #18 also said that after Employee #17 fed Resident #325 she should have left the resident at a 90-degree-angle (instead of flat) for 30 to 45 minutes, as per the facility's feeding protocol.

During a face-to-face interview on 06/13/23 at 12:05 PM, Employee #19 (Staff Development/RN) stated that Employee #17 (CNA) was educated on safely feeding residents and aspiration precautions during orientation. Employee #17 demonstrated competence in feeding residents. Additionally, Employee #17 also scored 100% on the aspiration precaution quiz.

2. The Resident #135 was admitted to the facility on 08/07/17 with diagnoses including Dysphagia, Type 2 Diabetes, Encephalopathy, Dementia, and Need for Assistance with Personal Care.

A review of Resident #135's medical record revealed a physician's order dated 04/04/23 at 1:49 AM which documented: "Regular diet. Mechanical Soft texture, Thin consistency, No

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{F 689}	Continued From page 31 Straws, strict aspiration precaution." A care plan revised on 05/18/23 documented [Resident #135] with low BMI (body mass index), mech (mechanical) soft diet, and altered skin integrity. Goal: Resident will tolerate modified diet safely x 90 days ...Interventions/Tasks: Diet: Mech Soft (no straws) ..." An Annual Minimum Data Set Assessment dated 05/22/23 documented that the Resident was cognitively intact, required extensive assistance with eating, and was on a mechanically -altered diet. During a tour and observation of Unit 2 South on 06/15/23 at approximately 11:30 AM, Resident #135 was lying in bed. There was one straw in a wrapper on the floor and another that was opened and sitting on the Resident ' s bedside table, along with a cup half filled with apple juice. A report entitled "Diet Type Report" dated 06/15/23 at 5:54 AM, documented: " ...Name: [Name of Resident]; Location: [Room of Resident]; Diet Type: Regular; Diet Texture: Mechanical Soft Diet; Fluid Consistency: Regular (Thin); Additional Directions: No Straws, strict aspiration precautions." During a tour and observation of Unit 2 South on 06/15/23 at approximately 11:30 AM, Resident #135 was lying in bed. There was one straw in a wrapper on the floor and another opened straw sitting on the Resident's bedside table, along with a cup half filled with apple juice. During a second observation on 06/15/23 at approximately 11:33 AM, Employee #8 (certified	{F 689}		

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{F 689}	Continued From page 32	{F 689}		

nursing assistant-CNA assigned to Resident #135) and the surveyor observed Resident in the room, lying in the bed. The straws were still in the Resident's room. There was one straw in a wrapper on the floor and another opened straw sitting on the Resident's bedside table, along with a cup half filled with apple juice.

A copy of the lunch meal tray ticket on 06/15/23 documented "No Straws."

During a face-to-face interview with Resident #135 on 06/15/23 at approximately 11:30 AM, the Resident stated that she did not remember who put the straws there. The Resident also reported that she had to tell the CNA that she couldn't have straws.

During a face-to-face interview on 06/15/23 at approximately 11:33 AM, Employee #8 (CNA caring for Resident #135) stated, "When I came in at approximately 9:00 AM. I provided ADL (assisted daily living) care for the Resident. Nothing was on the Resident's bedside table because I had cleaned it. I did not put the straws there. Maybe one of the other CNAs or somebody who handed out snacks did."

During a face-to-face interview on 06/15/23 at approximately 11:50 AM, Employee #7 (2 South Unit Manager) stated that she told Employee #8, when the Employee reported to the unit, that Resident #135 does not get straws. Employee #7 then stated that she would initiate an investigation and get statements from staff who worked with Resident #135 that morning.

During a telephone interview on 06/15/23 at 2:02 PM, when asked how she ensures that residents

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{F 689}	Continued From page 33	{F 689}		

are getting the correct diet and items on meal trays, Employee #9 (CNA), stated, "I checked the ticket and made sure what's on the ticket is what is on the plate. If it's a new resident, I will ask the Nurse. Nurses and CNAs are supposed to check the meal tickets before handing out trays. I have worked with Resident #135, who uses no straws. The Resident has a regular diet. I'm unsure if no straws are on her meal tickets, but if I saw them, I would take them out before entering her room.

A "Documentation Survey Report" report for June 2023 showed that from 06/09/23 to 06/16/23, Certified Nurses Assistants(CNAs) assisted Resident #135 with eating, drinking, and obtaining snacks. Of note, Employee #8 was noted as assisting Resident #135 with eating and fluid intake at 9:00 AM.

During a face-to-face interview on 06/16/23 at approximately 11:00 AM, Employee #11 stated that she was the day shift CNA usually assigned to Resident #135 but had not worked on 06/15/23 when the incident occurred. The Employee reported that the Charge Nurse huddles with CNA's to give reports on the residents, including their diets. The Employee added, "I have received training on resident meal trays and resident diets. If I saw straws in the Resident's room, I would take the straws out, inform the Charge Nurse and remind the other CNAs that the Resident is not supposed to have straws.

During a face-to-face interview on 06/16/23 at approximately 10:00 AM, Employee #7 stated, "After investigating the incident on 06/15/23, no staff owned up to seeing or leaving the straws in the Resident's room."

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{F 689}	Continued From page 34 Cross Reference 22B DCMR Sec. 3211.1	{F 689}		
{F 760} SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, for one (1) of 63 sampled residents, facility staff failed to safely store and administer medications in accordance with the acceptable standards of practice or manufactures specifications as evidenced by Employee #23 and #24 storing and administering expired Lantus (type of Insulin) medication to Resident #264. The findings included: Review of the facilities Plan of Corrections with a compliance date of 06/09/23 documented, " ...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 have the potential to be affected. Findings showed that no medication error occurred and that medications were properly stored ...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	{F 760}	1. R264 currently resides in the facility and has no ill effects. R264 was assessed on 6/14/23. Expired Lantus pen was discarded on 06/13/2023. E23, E24, E25 was educated on assuring that insulin pens and vials are checked to assure that it is not expired prior to administering and acceptable standards of practice based on manufactures specifications are followed. 2. All medication carts will be checked by the nurse manager or designee to assure no expired insulins are noted. All residents with an Insulin order have the potential to be affected by this deficient practice. Findings will be corrected immediately. 3. Licensed nurses (RN/LPN) will be educated by nurse educator or designee on the importance of following manufacturer specifications and assuring insulins are checked for expiration prior to administration. 4. Audits of insulins on the medication cart will be done by nurse manager or designee to assure that no expired insulins are noted on the medication carts. Audits will be done daily x 2 weeks, monthly x 3 until compliance is achieved. Any identified issues will be corrected. Results of the audits will be submitted to the QA and performance committee. Date of compliance 07/06/2023	

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{F 760}	Continued From page 35	{F 760}		

carts until compliance is achieved ..."

Resident #264 was admitted to the facility on 12/06/21 with diagnoses that included: Type 2 Diabetes Mellitus, Hypertension and End Stage Renal Disease.

Review of Resident's medical record revealed a physician's order dated 04/24/23 stating, "Lantus ... Subcutaneous Solution Pen-injector 100 Unit/ML (milliliters) ... Inject 12 units subcutaneously at bedtime for Diabetes Mellitus"

According to the manufactures specifications, " ...After 28 days, throw your opened Lantus pen away-even if it still has insulin in it ..." https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf

Review of the policy "Medication Administration" with a review date of 05/10/23 directed staff to, " ...identify expiration date. If expired, notify nurse manager ..."

Review of Resident #264's Medication Administration Record (MAR) for June 2023 showed that facility staff documented that Lantus was administered on 06/09/23 by Employee #23 (Registered Nurse/RN) and on 06/12/23 by Employee #24 (RN).

During an observation on 06/13/23 at 10:26 AM of the unit 2 south, mediation cart 3, Resident #264's Lantus pen documented, " ...Date open 05/11/2023 ... expiration 06/07/23 ..." At the time of the observation, Employee #25 (Licensed Practical Nurse/LPN) was asked about the expired Lantus pen. The employee stated, "I don't

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give it (Lantus) on my shift." It should be noted that further observation revealed that Resident #264 did not have any other Lantus pen stored in the unit's medication refrigerator.

During a face-to-face interview conducted on 06/15/23 at 5:05 PM with Employee #23 and #24, both employees stated that they received the in-service education on medication administration and storage. Employee #23 stated, "I did not take notice of the expiration date on the Lantus pen when I administered it (on 06/09/23)." Employee #24 stated, "I got a new [Lantus] pen on Monday (06/12/23)." When asked, Employee #24 could not explain where the new Lantus pen was nor could she explain why she failed to remove the expired Lantus pen from the medication cart.

During a face-to-face interview on 06/15/23 at approximately 5:20 PM, Employee #2 (Interim Director of Nursing) and Employee #14 (Staff Development/Educator) were made aware of the findings and did not provided any additional comments.

{F 761} SS=E Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2) — {F 761}

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and

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{F 761}	Continued From page 37 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews for six (6) of 63, sampled residents, facility staff failed to properly store medications according to standards of practice and manufacturer's medication specifications, as evidenced by 1. storing medications for Residents' #163 and #21 in medication cups on the medication cart, 2. storing Resident #204's and #159's medications together in the same compartment on the medication cart, 3. storing Resident #92's vial of Novolog insulin in the medication cart after the insulin expired, and failing to ensure that Resident #001, who was discharged, medications were not stored in the medication cart. (Residents' #163, #21, #204, #159, #92, and #001) The findings included: Review of the facility's Plan of Correction with a compliance date of 06/09/23 documented, " ...The Director of nursing or designee verified that the current resident's medications are properly	{F 761}	1. -R163 currently resides in the facility with no ill effects. R163 was assessed on 6/13/23 by MD. R21 currently resides in the facility with no ill effects. R21 was assessed on 6/13/23 by MD. R159 currently resides in the facility with no ill effect. R159 was assessed on 6/13/23 by MD. R92 currently resides in the facility with no ill effect. R92 was assessed on 6/14/23 by MD. R001 was discharged from the facility narcotics were disposed of appropriately on 6/13/23 by 2 licensed nurses. R163 and R21 pre-poured medications were discarded from the medication cart on June 13, 2023; R204's and R159's medications were separated from the same compartment in the medication cart on June 13, 2023; R92 expired Novolog insulin was discarded on June 13, 2023; R001 discharge resident meds were disposed of per policy on June 13, 2023. E15 LPN was educated by the Educator on June 15, 2023, not pre-pouring medications and Medications are never to be transferred into other containers at any time and destroying medications that are refused by residents. E15 was educated by the Educator on June 13, 2023, to assure that medications for each resident should be separated by dividers. E26 and E12, E13 were educated by the Educator on June 13, 2023, on checking expiry of insulin pens and vials in the medication carts. E21 and E22 was educated by the Educator on June 13, 2023, disposing of discharge resident medications if noted in cart; 2. All medication carts will be checked by the DON/Designee to assure that there are no pre-poured medications in the carts, medication carts have dividers separating residents' meds, all expired insulins/medications are noted and discharged resident meds are not noted in medication carts. All residents have the potential to be affected by this deficient practice. Findings will be corrected immediately. 3. Licensed professional nurses (RN/LPN) will be educated by Educator/Designee to assure that there are no pre-poured medications in the carts, medication carts have dividers separating resident meds, no expired insulins/medications are noted and discharged resident meds are not noted in medication carts. 4. Audits of med carts will be done by the DON/Designee to assure that there are no pre-poured medications in the carts, medication carts have dividers separating resident meds, no expired insulins/medications are noted and discharged resident meds are not noted in medication carts. Any identified issues will be corrected. Audits will be completed weekly times 4 then monthly times 3 or until compliance is achieved. Results of the audits will be submitted to the QA and performance committee. 5. Date of compliance 07/06/2023	

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stored in accordance with standards of practice on that expired medications are disposed of appropriately, that discharge medications are disposed of per protocol ... 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, that discharge medications are disposed of per protocol, that medication compartments of each resident have only those medications that are ordered for that resident ..."

1. Review of the facility's policy entitled, "Storage of Medications," revised on 06/01/23, documented, "... 3. All medications are stored in the original and properly labeled containers. Medications are never to be transferred into other containers at any time...."

1A. Resident #163 was admitted to the facility on 05/18/20 with diagnoses including Hypertension, Cerebrovascular Accident, Hemiplegia, Type 2 Diabetes Mellitus, Depression, and Anxiety.

A review of Resident #163's medical record revealed a physician's order dated 02/27/22 which directed: "Amlodipine Besylate tablet 10 mg (milligrams). Give one tablet by mouth one time a day for HTN (hypertension) hold for BP (blood pressure), or equal to 110/60."

A physician's order dated 04/27/23 directed: " Clonidine HCL Oral Tablet 0.3 mg (Clonidine HCL) Give 1 (one) tablet by mouth every 8 hours for hypertension."

A Quarterly Minimum Data Set Assessment dated

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05/18//23 documented that the Resident was cognitively intact.

1B. Resident #21 was admitted to the facility with diagnoses including Colon Cancer, Generalized Abdominal Pain, Fistula of the Intestine, and Schizoaffective Disorder.

A review of Resident #21's medical record revealed a care plan revised on 07/22/22 documenting: Focus : [Resident #21] has behavioral issues 1) non-adherent to treatment/medication ...Interventions ...Anticipate and meet [Resident #21]'s needs ...Explain all procedure(s) before starting and allow to adjust to changes ..."

A physician's order dated 05/19/23 at 8:00 AM, directed: "Magnesium oxide oral tablet 400 milligrams give one tablet by mouth 2 (two) times a day for supplement."

A physician's order dated 05/19/23 at 9:00 AM directed: "Folic acid world tablet one milligram give one tablet by mouth one time a day for elevated liver enzymes."

A Quarterly Minimum Data Set Assessment dated 05/22/23 documented that the Resident was cognitively intact and had received an antidepressant, an anticoagulant (a blood thinner), an antibiotic, and an opioid (narcotic used for pain) within the last seven days of the assessment.

A review of the facility's education and training records documented that Employee #15 attended an in-service on medication administration and storage on 05/22/23.

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{F 761}	Continued From page 40 During an initial tour of Unit 1-South on 06/13/23 at approximately 11:40 AM, Employee #15 (Licensed Practical Nurse/LPN), was observed standing outside Resident #163's room. The blood pressure machine and the medication cart were at the doorway of Resident 163's room. The Employee stated that she was about to check Resident #163's blood pressure before administering the Resident's blood pressure medication. When the Employee opened the top drawer of Medication Cart 1-South Team 2, two small unlabeled medication cups containing loose pills were observed. When asked who the medications belonged to, Employee #15 stated that one cup had Resident #163's blood pressure medications. After hesitating a few minutes, Employee #15 said that the other medication cup contained pills for Resident #21, who had refused to take the medications that morning. During a face-to-face interview on 06/13/23 at approximately 11:45 AM, Employee #15, when asked why the medications for Residents #163 and #21 were out of the blister packs and stored loosely in medication cups in the top drawer of the medication cart, the Employee stated that she was about to administer the Resident's blood pressure medication, but had to check the Resident's blood pressure to ensure that it was within the parameters to administer the medication. The Employee added that Resident #21 refused to take the morning medications. The surveyor then asked if the Employee knew what to do with the medications when a Resident refused. The Employee then stated," Oh, I should discard them. I will do it now," and the Employee discarded the pills for Resident #163 in the sharp container on the medication cart. The Employee	{F 761}		

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stated that she had received medication administration and storage education sometime last month.

During a face-to-face interview on 06/13/23 at approximately 12:00 PM, Employee #5 (1 South Unit Manager) stated that nurses should not store the Residents medications opened and in medication cups on the medication cart. He added that Employee #15 should have destroyed the medications refused by Resident #21 immediately and should not have placed the medications back in the medication cart.

During a face-to-face interview, Employee #14 (Staff Development Educator) stated that she provided a test during the in-service training on 05/22/23 to demonstrate the Nurses' competency in medication administration and storage. The Employee said that she looked for Employee #15's competency test and could not locate it.

2. A review of the facility's policy entitled "Storage of Medications," revised on 06/01/23, documented, " ...Each Resident drawer in the medication cart is labeled to identify the Resident's name and room number....."

A review of the facility's plan of correction with a compliance date of 06/09/23 documented, "4. The Pharmacy consultant/designee will audit medication carts to ensure that the Resident's medications are properly stored ... that each medication compartment of each Resident does not have other residents' medications .... "

2A. Resident #205 was admitted to the facility on 08/23/21 with diagnoses including Gout, Heart Failure, Essential Hypertension, Morbid Obesity,

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and Adjustment Disorder with Anxiety.

A physician's order dated 03/24/22 documented: "Allopurinol Tablet 100 mg (milligrams). Give one tablet by mouth one time a day for Gout."

A review of Resident #205's medical record revealed a Quarterly Minimum Data Set Assessment dated 06/02/23 documenting that the Resident was cognitively intact.

2B. Resident #159 was admitted to the facility on 08/16/18 with diagnoses including Heart Failure, Peripheral Vascular Disease, Essential Hypertension, and Cerebral Infarct.

A review of Resident #159's medical record revealed a physician's order dated 11/01/21 documenting, "Spironolactone Tablet 25 mg. Give one tablet by mouth one time a day for Congestive Heart Failure. Hold for SBP (systolic blood pressure) < (greater than) 100 or DBP (diastolic blood pressure) < (less than) 60. 'hazardous handling.' "

A Quarterly Minimum Data Set Assessment dated 05/03//23 documented that the Resident was cognitively intact and had received an antidepressant and a diuretic (a blood pressure medication also used to treat fluid retention) within the last seven days of the assessment.

During an observation and review of Medication Cart 1 South Team 2 on 06/13/23 at approximately 11:40 AM with Employee #15, the surveyor observed that Resident 205's medication was stored in the same compartment as Resident 159's medication. Of note, there was no rubber band or separation divider between the

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two residents' medications. Directly behind Resident #205's (Allopurinol- a medication for Gout) was Resident #159's (Spironolactone - a blood pressure medication.)

During a face-to-face interview on 06/13/23 at approximately 11:44 PM, Employee #15, when asked why Residents 205's and Resident 159's medication was in the same compartment in the medication cart with no separation divider between them, the Employee stated that she had noticed this earlier and had searched the medication cart, but found no additional partition dividers. The Employee acknowledged the finding and added, "I meant to ask the Unit Manager about more dividers earlier."

During a face-to-face interview on 06/13/23 at approximately 12:00 PM, Employee #5 (1 South Unit Manager) stated that Nurses should audit the medication carts every shift ...Partition dividers should separate each Resident's medication from another. The Employee added that he had extra dividers, and the Nurse attending the cart should have said something to him.

3. A review of the facility's policy entitled, "Storage of Medications," revised on 06/01/23, documented, "... 5. Medications should be kept in the facility in accordance with manufacturers guidelines ..."

A review of the manufacturer's guidelines for Novolog (Aspart) insulin directed: "Store unused NovoLog® pens, PenFill® cartridges, and vials at room temperature up to 86°F for up to 28 days ... Dispose after 28 days, even if there is insulin left in the pen or vial."
(https://www.mynovoinsulin.com/insulin-products/

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{F 761}	Continued From page 44 novolog/taking-novolog.html) A review of the facility's plan of correction with a compliance date of 06/09/23 documented, "4. The Pharmacy consultant/designee will audit medication carts to ensure that the Resident ' s medications are properly stored in accordance with standards of practice, that expired medications are disposed of appropriately ... ...that each medication compartment of each Resident do not have other residents ' medications .... " Resident #92 was admitted to the facility on 05/15/15 with diagnoses including Type 2 Diabetes Mellitus, Cerebrovascular Disease, and Cognitive Communication Deficit. A review of Resident #92's medical record revealed a physician's order dated 12/18/20 which directed: "Novolog Solution 100 units/ml (milliliter) (Insulin Aspart). Inject as per sliding scale: If [blood sugar] 151 - 200 = [Give] 2 units, 201-250 = 4 units; 251 - 300 = 6 units; 301-350 = 8 units; 351-400 = 10 units, subcutaneously before meals and at bedtime for DM (Diabetes Mellitus) call MD/NP (Medical Director/Nurse Practitioner for BS (blood sugar) > (greater than) 400 or < (less than) 60." A Quarterly Minimum Data Set Assessment dated 06/02/23 documented that the Resident was cognitively intact and on insulin. Review of Resident #92' s Medication Administration Record (MAR) for 06/09/23 to 06/13/23 documented the following: -06/09/23: BS (blood sugar) = 85, 90, 87, 101 - no	{F 761}		

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{F 761}	Continued From page 45 insulin administered; -06/10/23: BS = 85, 118, 113, 177- (insulin administered for blood sugar of 177. * insulin expiration date); -06/11/23: BS = 80, 86, 132, 109 - no insulin administered; -06/12/23: BS = 118, 122, 97, 109 - no insulin administered; -06/13/23: BS = 85, 108- no insulin administered. During an observation and review of Medication Cart 2 South Team 1 on 06/13/23 at 3:49 PM with Employee #6 (2 South Unit Manager), a vial of Novolog insulin for Resident #92 with an opened date of 05/13/23 and expiration date of 06/10/23, was observed in the medication cart. Employee #26, the Nurse responsible for the medication cart on the day shift, was not available to review the medication cart. During a face-to-face interview on 06/13/23 at 3:53 PM with Employee #6 (2 South Unit Manager), stated that the Nurses are supposed to check the medication cart at the beginning of each shift, and the Nurse responsible for Medication Cart 2 South Team 1 last checked the cart that morning. The Employee then provided a "Medication Verification Form," which was checked off by the Nurse (Employee #26). Employee #6 reportedly also performed random audits of the cart, and stated he/she didn't know how this was missed. Employee #6 then presented an audit sheet completed on 06/09/23 and stated that was the last time sheet she had conducted an audit on the medication cart. During a telephone interview on 06/16/23 at 10:14	{F 761}		

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AM, Employee #12 (Registered Nurse/RN), when asked about the Resident, stated: "After administering the last dose of insulin on 06/10/23, I was supposed to discard the bottle. I cannot recall if I did this or not. The Employee added, "Medication carts are checked by the nurses every shift and every day. I check the medication cart every shift. The unit managers or Assistant Director of Nursing/ADON check the medication carts randomly. When the Nurse notices that the insulin is expiring, the Nurse should remove it and let the pharmacy know, so they can review the physician's order and order a new vial of insulin." When asked about education and training for medication storage, the Employee acknowledged that he had received training recently but could not recall the exact date.

During a telephone interview on 06/16/23 at 10:20 AM, Employee #13 (Agency Registered Nurse/RN) stated, "I worked with the Resident on 06/11 /23. When the Nurses come in at the start of the shift, they are supposed to check the medication cart. I am not sure if I checked the cart right away or not when I last worked with the Resident, but usually, that's the first thing I do. I do not recall seeing any expired medications. When the Nurse sees an expired medication, the Nurse is supposed to take it out of the cart, call the pharmacy to order, and replace it. We put the expired medication in a bag to return to the pharmacy." When asked about education and training for medication, the Employee replied, "I recall on a Sunday getting an in-service training on abuse and rights of medication."

During a face-to-face interview on 06/15/23 at 9:48 AM, Employee #14 (Staff Development Educator) stated that facility and agency staff

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{F 761}	Continued From page 47 nurses had been trained on medication storage and were required to complete competency tests. The Employee then provided competency tests for Employees #12, #13, and #26. All three employees scored 100% on their competency tests. 4. Resident #001 was admitted to the facility on 03/20/23 to unit1 North room 113- bed A with diagnoses that included: Idiopathic Gout, Pain in Right Knee, and Acute Kidney Failure. Review of Resident #001's medical record revealed the following a 04/24/23 at 11:30 AM Nurses Note stating, " ... Discharged teaching [taught] to resident and sister and they both verbalized understanding ... Resident stable at time of discharge ... [Medical doctor] aware of resident's discharged." A 04/24/23 at 11:54 AM Social Services Note documented, "6108-form was completed /faxed to the ombudsman office and emailed to the Department of Health for the discharge to the community that occurred on 4/24/2023." During an observation of the team 1 medication cart on unit 1 North on 06/13/23 at 9:55 AM with Employee #22 (Licensed Practical Nurse/LPN), the following was observed: one blister packet labeled "[Resident #001] ... Oxycodone ... 5MG tab ..." that contained 24 tablets; a second blister packet labeled "[Resident #001] ... Oxycodone ...5MG tab ..." that contained 25 tablets. When asked was she aware that Resident #001 had been discharged, Employee #22 stated, "Yes. He was discharged a while ago." The employee also	{F 761}		

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	095022	A. BUILDING ______ B. WING ______	R-C 06/16/2023

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{F 761}	Continued From page 48 stated that the protocol is that the nurse who discharges or transfers the resident has to inform their supervisor or unit manager so that the medications can either be destroyed or returned to the pharmacy. Employee #22 stated that even though she was aware that Resident #001 had been discharged, she did not inform anyone that his narcotic medications were still in medications in the cart. During a face-to-face interview conducted on 06/13/23 at 11:34 AM, Employee #21 (Educator/former Director of Nursing) stated that she conducted an audit of the team 1 medication cart on unit 1 North on 06/09/23 but did not pick up that Resident #001 had two blister packs of narcotics still in the cart. Cross Reference 22B DCMR Sec. 3227.13	{F 761}		
{F 865} SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and	{F 865}		

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{F 865}	Continued From page 49 documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.	{F 865}		

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{F 865}	Continued From page 50 §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to	{F 865}	1.Employee #16 (Director of Quality Improvement) will be educated by RDO/designee on June 27, 2023, to assure that the facility continuously monitor identified deficient practices from the prior recertification survey and to implement Quality Assurance and Performance Improvement (QAPI) process as indicated in their Plan of Correction. 2. Each of the identified deficient practice will be reviewed by the QAPI committee on June 28, 2023, to assure that facility continues to monitor the Quality Assurance and Performance Improvement (QAPI) process and revise plan as necessary. All residents have the potential to be affected by this deficient practice. Findings will be corrected immediately. 3. QAPI committee will be educated by Regional clinical consultant/designee to assure that facility continues to monitor the Quality Assurance and Performance Improvement (QAPI) process and revise plan as necessary. 4. Review of the deficient areas will be done by (Director of Quality Improvement)/designee to assure sustained compliance. Reviews will be done weekly x 4 then monthly times 3 or until compliance is attained. Any identified issues will be corrected. Results of the audits will be submitted to the QA and performance committee. 5. Date of compliance 07/06/2023	

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{F 865}	Continued From page 51 the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to continuously monitor identified deficient practices from the prior recertification survey and to implement their Quality Assurance and Performance Improvement (QAPI) process as indicated in their Plan of Correction with a compliance date of 06/09/2023. The resident census on the first day of the survey was 297. The findings included: Review of the facility's Plan of Corrections with a compliance date of 06/09/23 stipulated, " ... A QAPI plan was developed on 05/11/2023 to ensure that residents are free from abuse, neglect, and exploitation ...A QAPI plan was initiated on 01/01/2023 to ensure that residents are free from accident hazards/supervision/devices and revised 05/11/2023. A QAPI plan was developed on 05/11/2023 to ensure that residents are free from significant medication error ...The Director of quality improvement or designee will review audits completed to assure that corrective actions demonstrate sustained compliance of areas identified ..." A review of the facility's previous survey (Federal Recertification Survey) conducted from	{F 865}		

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{F 865}	Continued From page 52 02/10/2023-03/10/2023 showed that the facility was cited for the following deficiencies: F600 - Free from Abuse and Neglect F607 - Develop/implement abuse/neglect policies F609 - Reporting of Alleged Violations F656 - Develop/implement comprehensive care plan F684 - Quality of care F689 - Free of Accident Hazards/supervision/devices F760 - Residents are free of significant med errors F761 - Label/store dugs and biologicals The aforementioned deficiencies were cited again during the Revisit Survey that ended on 06/16/2023. According to Employee #16 (Director of Quality Improvement), the last QAPI meeting was conducted on 05/25/2023. On 06/16/23 at 5:00 PM, a face-to-face interview was conducted with Employees #1 (Administrator), #2 (Interim DON), and #16 regarding the Quality Assurance and Performance Improvement (QAPI) plan for the development and implementation of appropriate corrective and preventive actions. Employee #16, acknowledged the findings and stated that the IDT (Interdisciplinary Team) will continue to review any findings to identify the root causes and initiate measures to sustain and improve compliance.	{F 865}		