STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	C 10/20/2023

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BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL	223 7TH STREET NE WASHINGTON, DC 20002

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F 000	INITIAL COMMENTS	F 000		

An unannounced Complaints/Facility Reported Incidents (FRI) Survey was conducted at this facility from October 11, 2023, to October 20, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 105 and the survey sample included eleven (11) residents.

The following Complaints were investigated:
DC~10623, DC~11263, .DC~11728, DC~11891, DC~11954 and DC~12321,

The following Facility Reported Incidents were investigated:
DC~11870, DC~12296, DC~12402, and DC~12378

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

Citations are being cited for: DC~12402 and DC~11263.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	11/17/2023

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

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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
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

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F 000	Continued From page 2 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 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	F 000		
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 source and misappropriation of resident property,	F 609	Corrective action 1) Resident #3 and resident # 5 verbal abuse allegation initial report was completed and sent to DOH on 5/8/2023 but the final report was not sent to DOH.	

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F 609	Continued From page 3 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 reviews and staff interviews, for one of eleven (11) sampled residents, facility staff failed to report the results of its investigation for an incident involving resident-to-resident verbal abuse to the State agency within five (5) working days of the incident. Residents #3 and #5. The findings included: Review of the facility's policy entitled "Abuse Investigation and Reporting"documented: "The Administrator or his/her designee will provide the appropriate agencies or individual ...with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident."	F 609	Identifying other residents 2) All residents involved in allegations of abuse self-report could be affected. Self-reports completed in the last 30days prior to survey visit will be audited by the administrator to ensure that the final report is sent to DOH within 5 working days. Any deficiencies will be corrected. Systemic change 3) Regional Director of clinical operations will in=service the administrator and the Director of Nursing on ensuring that all self-reports related to abuse final report is sent to DOH within 5 business days. The Director of Nursing will in-service nurse managers and nurse supervisors on ensuring that all self-reports related to abuse are sent to DOH within 5 working days. Any deficiencies will be corrected. Monitoring corrective actions 4) The Administrator/DON will audit all allegation of abuse self-reports weekly x 3 months to ensure that all final self-reports are reported to DOH within 5 working days. All findings will be reported monthly to the QAPI committee for (3) consecutive months for recommendations, monitoring and education as needed.	

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F 609	Continued From page 4 1. Resident #5 was admitted to the facility on 07/07/22 with diagnoses including Metabolic Encephalopathy, Chronic Respiratory Failure, Hemiplegia, Muscle Weakness, Adjustment Disorder with Mixed Anxiety and Depressed Mood. Review of Resident #5's medical record revealed the following: A physician's order dated 08/18/22 directed: "Quetiapine Fumarate 25 mg. Give 0.5 mg tablet by mouth every 12 hours for Psychosis." A physician's order dated 04/14/23 directed: "Psych consult for anxiety." A Quarterly Minimum Data Set (MDS) assessment dated 02/06/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "12," indicating the Resident had mildly impaired cognition and the Resident had no indicators of psychosis or behavioral symptoms. A care plan initiated on 05/08/23 documented: "Focus Verbal aggression received from [Resident #3] on 05/07/2023. Goal: [Pronoun] will feel save (safe) through the review date. Interventions: [Pronoun] was educated to talk to staff if [Pronoun]has any concern; [Pronoun] verbalized understanding ..." 2. Resident #3 was admitted to the facility on 12/16/22 with diagnoses including Chronic Respiratory Failure, Encounter for Attention to	F 609	Date correction was completed. 1) Date of compliance will be November 27th 2023	

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F 609	Continued From page 5	F 609		

Gastrostomy, Perforation of Esophagus, Esophageal Obstruction, and Pyothorax Without Fistula.

Review of Resident #3's medical record revealed the following:

A Quarterly Minimum Data Set (MDS) assessment dated 03/25/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "15," indicating the Resident had intact cognition. In addition, Resident #3 was coded as having no indicators of psychosis or behavioral symptoms and used no mobility device to ambulate.

A care plan initiated revised on 05/10/23 documented: "Focus: [Resident #3] is/has potential to be verbally aggressive r/t (related to) poor impulse control ... Interventions: [Resident #3] had a verbal altercation with another resident [Resident #5] on the 5th floor ..."

A Department of Health (DOH) Complaint/Incident Report # 11870 Form dated 05/08/23 at 4:57 PM documented: "The Charge Nurse heard Resident #3 screaming at Resident #5 in the hallway, stating '[expletive], shut up. 'Upon interview with Resident #3, [Pronoun] explained that Resident #5 was sitting on the couch in front of the elevator saying the "F "word to no one. When Resident #5 saw Resident #3, [Pronoun] followed [Pronoun] to come sit down on the couch. Resident#3 then said to Resident #5, 'Leave me alone.' Resident #3 denied cursing at Resident #5. The charge nurse separated them. Resident #3 was assured of safety and informed of [other] Resident's rights to move around the

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F 609	Continued From page 6	F 609		

facility. [Resident #3] was also educated to refrain from using profanity and to talk to staff if [Pronoun] has any concerns ...The couch was removed. [Physician' Name], the Psychiatrist made aware of Resident #3's verbal altercation with another resident ..."

A review of the facility's investigation packet of the incident revealed the following:

A written statement from a Resident in a nearby room who witnessed the incident documented: "[Name of Resident #3] approached [Name of Resident #5] who was sitting on the couch close to the elevator about [Pronoun] laughing. This seemed to bother [Pronoun], and the Resident was not happy, especially since [Name of Resident #5] was sitting on the couch that [Resident #3] is always sitting on. This ended up with them cursing each other."

A written statement of Employee # 7/Registered Nurse that documented: "I was by the medicine cart crushing meds when I heard [Resident #3] screaming at [Resident #5] using the word '[expletive], Shut up.' I walked [Pronoun] away from [Resident #3] and called the Supervisor.

A written statement of an interview with [Resident #5] that documented: [Resident #5] reported that today, 5/7/23, [Pronoun] was sitting at the front elevator on the 5th-floor seat. While waiting for [pronoun] mother and sister, [Resident #3] said to [Resident #5], 'You know that's where I sit, and everyone knows that [expletive]. Shut up.' [Resident 35] got up and offered [Resident #3] the seat. [Resident #3] walked away and said [expletive]. [Resident#5] followed [Pronoun] to apologize [Resident #3] and said to [Pronoun]

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F 609	Continued From page 7	F 609		

'Leave me alone ..."

Resident #5 was discharged home at the time of the survey and was unavailable for interview.

Resident # 3 who still resides in the facility was available for interview.

During a face-to-face interview on 10/20/23 at 12: 42 PM, when asked about the incident, Resident #3 stated that the Resident was with [pronoun] sister, who was also a resident at the facility. Resident #5 and the Resident's sister often laughed at Resident #3, when the Resident walked by. I used to sit on the bench in front of the elevator to watch my movies and everyone knows that. On the day of the incident, when I was walking toward the bench, I noticed Resident #5 was sitting on the bench, so I kept walking. Resident #5 saw me and followed me, asking me to come and sit down next to [pronoun] on the bench. I told [pronoun] to 'Get away from me.' Resident #5 then cussed at me first and I cussed back at the Resident. The Administrator then moved the bench in front of the elevator and said he would return it when either I or Resident #7 was discharged.

Review of Residents #3's and #5's medical records and review of the facility's investigation records of the verbal altercation between Residents #3 and #5 lacked documented evidence that facility staff reported its findings to the State agency within five (5) working days of the incident.

During a face-to-face interview on 10/20/23 at 2:40 PM, Employee #1, Administrator, stated that the facility reported the incident to the State

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F 609	Continued From page 8 agency, took verbal statements from the residents, and witnesses moved the couch from in front of the elevator, so no other incident like that one would happen between the Residents, and completed their investigation of the incident. There were no other incidents over the bench since then, so the facility thought that was the end of that concern. Employee #1 acknowledged that the facility did not send a final report of its findings to the State agency within five (5) days of the incident.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657	Corrective action 1) Resident # 3 care plan was update on 11/16/23 to include interventions as documented by psych NP on 5/9/2023 Identify other residents. 2) All residents involved in allegations of abuse self-report could be affected. Care plans for self-reports completed in the last 30 days prior to survey will be audited by the Director of Nursing or designee to ensure that their care plan related to abuse was updated for each incident. Any deficiencies will be corrected.	

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F 657	Continued From page 9 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews for (1) of eleven sampled residents, facility staff failed to update Resident #3's care plan interventions after the Resident had another verbal altercation with a second resident (Resident #5). The findings included: 1.Resident #7 and Resident #3 had a verbal altercation on 04/09/23. A. Resident #7 was admitted to the facility on 09/28/21 with diagnoses including Cerebral Palsy, Type 2 Diabetes Mellitus, Chronic Respiratory Failure, Tracheostomy, Gastrostomy, Psychotic Disorder, Depression, Anxiety, and Bipolar Disorder. Review of Resident #7's medical record revealed the following: An Admission Minimum Data Set (MDS) assessment dated 10/05/21 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of, "8," indicating the Resident had moderately impaired cognition. In addition, facility staff coded the Resident as rejecting care and having verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) for 1-3 days of the assessment. The Resident was coded as totally dependent on staff for mobility,	F 657	Systemic Changes 3) Regional Director of clinical operations will in-service the Director of Nursing on ensuring that care plans related allegation of abuse is updated for each incident. Nurse The Director of Nursing will in-service Nurse Managers and Nurse Supervisors on ensuring that care plans related to allegation of abuse self-reports are updated for each incident. Any deficiencies will be corrected. Monitoring corrective action 4) The Director of Nursing will audit care plans related to allegations of abuse self-reports to ensure that they are updated for each incident weekly x 3 months. All findings will be reported monthly to the QAPI committee for (3) consecutive months for recommendations, monitoring and education as needed. Date correction was completed. 1) Date of compliance will be November 27th 2023	

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F 657	Continued From page 10	F 657		

requiring extensive assistance for all other ADLs (assisted daily living skills - grooming, dressing, personal hygiene, transfer.

A physician's order dated 02/14/23 at 9:00 PM directed: "Diphenhydramine HCl Capsule 25 mg. Give one (1) capsule by mouth at bedtime for Anxiety."

A physician's order dated 03/02/23 at 9:00 PM, directed: "Quetiapine Fumarate Tablet 25 mg. Give 25 mg by mouth two times a day for Bipolar D/o (disorder)."

A Psych Progress Note dated 03/07/23 documented: "Chief complaint: follow-up on medication changes, mood, and behavior: 1. Seroquel started last week due to agitation, and mom reported Bipolar hx (history). 2. off Olanzapine x 2 weeks r/t (related to) possible adverse effects ..."

B. Resident #3 was admitted to the facility on 12/16/22 with diagnoses including Chronic Respiratory Failure, Encounter for Attention to Gastrostomy, Perforation of Esophagus, Esophageal Obstruction, and Pyothorax Without Fistula.

Review of Resident #3's medical record revealed the following:

A physician's order dated 12/19/22 at 12:00 AM directed "Dilaudid Tablet 2 MG (Hydromorphone HCl). Give two (2) tablets via G-Tube every 4 hours for pain."

A physician's order dated 03/12/23 directed:

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F 657	Continued From page 11	F 657		

"Trazadone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet via G-Tube at bedtime for Depression and insomnia."

A Quarterly Minimum Data Set (MDS) assessment dated 03/25/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "15," indicating the Resident had intact cognition. In addition, Resident #3 was coded as having no indicators of psychosis or behavioral symptoms and used no mobility device to ambulate.

A Department of Health (DOH) Complaint/Incident Report Form dated 04/10/23 at 7:56 PM documented: "At approximately 4:00 PM on 04/10/23, Resident [Name of Resident who witnessed incident] reported to the 5th Floor Unit Manager that on April 9th, 2023, at around midafternoon that [pronoun] witnessed [Resident #3] verbally abusing [Resident #7]. [Pronoun] heard [Resident #3] using the word, 'what the F- is wrong with you, no gives(s) an F- about you and nobody cares about you'. It was also reported by [Resident who witnessed incident] that [Resident #7] started talking to herself and appeared distressed. Dr. Fritzner was made aware at 6:17 pm, new order for Psych consults for both patients ..."

A care plan initiated on 04/10/23 documented: "Focus [Resident #3] is/has potential to be verbally aggressive r/t (related to) poor impulse control. Goal: [Resident #3] will demonstrate effective coping skills through the review date. Interventions: Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; [Resident #3] was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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educated to keep a distance from [Resident #7] and refrain from using profanity towards resident/other resident; [Resident #3] 's triggers for verbal aggression are (another residents behavior); [Resident #3] 's behavior is de-escalated by him walking away; Psychiatric consult as indicated; When [Resident #3] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later."

A Department of Health (DOH) Complaint/Incident Report Form dated 04/14/23 at 1:26 PM documented: "This is a follow-up on the report, submitted on 04/10/2023 regarding witnessed Resident-to-Resident Verbal Abuse ...Based on staff and resident interview, and eyewitness account of [Resident who witnessed incident]. [Resident #7] and [Resident #3] did have a verbal altercation. Investigation was able to substantiate a verbal altercation between two residents. [Resident #3] was educated to refrain from using profanity and informed to keep a distance from [Resident #7] during [pronoun] episodes of verbal outbursts. [Resident #3] was also encouraged to notify staff if [pronoun] had any concerns with other residents or staff..."

2. Residents #5 and # 3 had a verbal altercation on 05/08/23.

A. Resident #5 was admitted to the facility on 07/07/22 with diagnoses including Metabolic Encephalopathy, Chronic Respiratory Failure, Hemiplegia, Muscle Weakness, Adjustment

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	095027	A. BUILDING _____ B. WING _____	C 10/20/2023

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Disorder with Mixed Anxiety and Depressed Mood.

Review of Resident #5's medical record revealed the following:

A physician's order dated 08/18/22 directed: "Quetiapine Fumarate 25 mg. Give 0.5 mg tablet by mouth every 12 hours for Psychosis."

A physician's order dated 04/14/23 directed: "Psych consult for anxiety."

A Quarterly Minimum Data Set (MDS) assessment dated 02/06/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "12," indicating the Resident had mildly impaired cognition and the Resident had no indicators of psychosis or behavioral symptoms.

A care plan initiated on 05/08/23 documented: "Focus - Verbal aggression received from [Resident #3] on 05/07/2023. Goal: [Pronoun] will feel save (safe) through the review date. Interventions: - [Pronoun] was educated to talk to staff if [Pronoun]has any concern; [Pronoun] verbalized understanding;"

B. Resident #3 was admitted to the facility on 12/16/22 with diagnoses including Chronic Respiratory Failure, Encounter for Attention to Gastrostomy, Perforation of Esophagus, Esophageal Obstruction, and Pyothorax Without Fistula.

Review of Resident #3's medical record revealed the following:

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A physician's order dated 12/19/22 at 12:00 AM directed "Dilaudid Tablet 2 MG (Hydromorphone HCl). Give two (2) tablets via G-Tube every 4 hours for pain."

A physician's order dated 03/12/23 directed: "Trazadone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet via G-Tube at bedtime for Depression and insomnia."

A Quarterly Minimum Data Set (MDS) assessment dated 03/25/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "15," indicating the Resident had intact cognition. In addition, Resident #3 was coded as having no indicators of psychosis or behavioral symptoms and used no mobility device to ambulate.

A Department of Health (DOH) Complaint/Incident Report #11870 Form dated 05/08/23 at 4:57 PM documented: "The Charge Nurse heard Resident #3 screaming at Resident #5 in the hallway, stating '[expletive], shut up. 'Upon interview with Resident #3, [Pronoun] explained that Resident #5 was sitting on the couch in front of the elevator saying the "F "word to no one. When Resident #5 saw Resident #3, [Pronoun] followed [Pronoun] to come sit down on the couch. Resident#3 then said to Resident #5, 'Leave me alone.' Resident #3 denied cursing at Resident #5. The charge nurse separated them. Resident #3 was assured of safety and informed of [other] Resident's rights to move around the facility. [Resident #3] was also educated to refrain from using profanity and to talk to staff if [Pronoun] has any concerns ...The couch was

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removed. [Physician' Name], the Psychiatrist made aware of Resident #3's verbal altercation with another resident ..."

A Revised Care plan dated 05/08/23 documented: " ...Interventions: [Resident # 3] had a verbal altercation with another resident on the 5th floor on 05/07/2023; [Psychiatrist Name] made aware of [Resident #3] 's verbal altercation with another resident. Presently [pronoun] is on Psych case load due to diagnoses of Anxiety Disorder, Depression, and History of Psychoactive Substance Abuse; [Physician Name] made aware on 05/08/2023. [Resident #3] is responsible for self; Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; [Resident #3] 's triggers for verbal aggression are (another residents behavior); [Resident #3] 's behavior is de-escalated by him walking away; Psychiatric consult as indicated; When [Resident #3] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later."

Review of Resident #3's medical record lacked documented evidence that facility staff updated the Resident's care plan interventions after the Resident had a second verbal altercation.

During a face-to-face interview on 10/20/23 at 12:45 PM, when asked about updating Resident #3's care plan after the second verbal altercation with a resident, Employee #2 /Director of Nursing stated, "We may have missed it," and she acknowledged the finding.

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews of (1) of eleven sampled residents, facility staff sat at the nurse's station and failed to respond to a resident's room while the ventilator alarmed continuously to alert staff of a ventilator emergency when the HME (heat moisture exchange) tubing had dislodged from the resident's tracheostomy collar for longer than one minute. (Resident #8). The findings included: Resident #8 was admitted to the facility on 02/11/21 with multiple diagnoses that included: Chronic Respiratory Failure, Tracheostomy, Ventilator Dependent, Dementia, Anxiety, Cerebral Vascular Accident with Left Hemiparesis, Sigmoid Volvulus, Bowel Resection, Gastrostomy, Congestive Heart Failure and Morbid Obesity. A Physician order dated 02/11/21 documented,	F 695	Corrective action 1) Resident # 8 call light was responded to by staff at 3:12 pm on 10/19/2023 and his vent HME tubing was placed correctly by charge nurse to ensure that the resident is receiving warm and humidified air in the respiratory tract. Resident # 8 did not suffer any adverse effects. Identifying other Residents 2) All residents on the 6th floor with ventilators have the potential to be affected. Residents on ventilators on the 6th floor were checked by the director of nursing on 10/19/23 and all had their HME tubing connected properly receiving warm and humified air. No other residents had their red flashing light to indicate the need for assistance with their ventilator. All residents in the facility have the potential to be affected related to call light not been responded to timely. The director of nursing chooses one room on each floor turned on the light to assess timely response to call light, all call lights were responded to within 5-10minutes on 10/19/2023. Any deficiencies will be corrected.	

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F 695	Continued From page 17 "Trach (tracheostomy) care and suctioning q (every) shift and PRN (as needed) by Nursing/RT (Respiratory Therapist)." A Care Plan focus area dated 09/07/21 documented, "[Resident's name] has an ADL self-care performance, incontinence deficit r/t (related to) Dementia, Hemiplegia, Impaired balance." An Annual Minimum Data Set (MDS) Assessment dated 09/03/22 documented, the facility staff coded a Brief Interview for Mental Status (BIMS) score of '15,' indicating the resident was cognitively intact and functional status documented, 2-person assistance for bed mobility, transfer and toilet use. A Complaint # 11263 dated 11/28/22 AT 12:31 PM documented, "[Resident's name] is a resident at [Facility's name]" and "On 11/25/22, says that she rang the call light several times and it went unanswered for several hours." A Call Bell Assessment Questionnaire dated 09/29/23 documented, "Is the resident oriented to person? Yes; Is the resident oriented to environment? Yes; Is the resident able to verbalize their needs? No; Is the resident able to reach call bell system? Yes; Is the resident able to use call bell device on command? Yes." A Physician order dated 09/30/23 documented, "Vent (ventilator) settings: tv (tidal volume) 450 - fio2 (fraction of inspired oxygen) 30% - rate 15 - peep (positive end-expiratory pressure) 5 every shift for resp (respiratory) failure." During an observation conducted on 10/19/23 AT	F 695	Systemic Changes 3) Director of Nursing will In-service all License Nurses on certified nursing assistant on ensuring that call lights are responded to within 5 minutes, and License Nurses are ensuring that ventilator HME tubing that are dislodged are correctly placed to ensure that residents on ventilators are receiving warm and humidified air. Any deficiencies will be corrected. Monitoring Corrective action 4) The DON/UM/Shift Supervisors/Respiratory Therapsit will conduct random rounds on the Unit to ensure that call lights are being responded to by staff within 5-10 minutes and ventilator HME tubing that are dislodged will be correctly placed to ensure that residents with ventilator are receiving warm humidified air, to also ensure that resident needs are met. All findings will be reported to the QAPI committee for (3) consecutive months for recommendations, monitoring and education as needed. Date correction was completed. 1) Date of compliance will be November 27th 2023.	

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10:35 AM, Resident #8, a ventilator-dependent resident, was lying in bed watching TV, tracheostomy intact and collar in place and was self-suctioning oral secretions.

On 10/19/23 AT 2:55 PM the State Surveyor returned to Resident #8's room and asked the resident to activate the call bell device to observe the staff's response for assistance. At 3:03 PM there was still no response to the call for help. The State Surveyor then checked to see if the call light above the resident's room door was illuminated and found that the White call light was on. At approximately 3:05 PM, the resident's head turned to look down to grab the oral suctioning tubing, and then the HME (heat moisture exchange) tubing dislodged from tracheostomy collar and the ventilator unit alarmed then stopped. When that happened, the State Surveyor went back to the door to look for nursing staff or respiratory staff and approximately 15-20 seconds later, the ventilator unit started to alarm continuously. The call light above the resident's room door had started flashing Red and the ventilator alarm could be heard in the hallway. The State Surveyor looked out in the hall again to find facility staff and there were no staff seen in the hallway. The State Surveyor proceeded to walk approximately 20 feet to the front desk/nurse's station and observed Employee #5 (CNA, Certified Nursing Assistant) sitting at the desk in front of the Resident call bell notification device that indicated Resident #8's room number and "Vent Assistance" flashing Red. The State Surveyor explained what happened and asked Employee #5 if [pronoun] was aware that the resident needed assistance. Employee #5 stated, "I will go find the nurse" then walked away from the

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nurse's station to find the assigned nurse. The State Surveyor turned to walk with Employee #5 and saw two nursing staff, Employee #3 (RN, Registered Nurse) and Employee #4 (RN, Registered Nurse), walking from the other end of the hallway towards the nurse's station where the State Surveyor was standing. They did not go to the room where the light was flashing Red to assess why there was a continuous high-pitched alarm. They went to an area behind the nurse's station, sat down at a desk and started to talk amongst themselves. The State Surveyor approached them at approximately 3:09 PM, explained what happened and asked if they would assist the resident. At that point, they stood back up and walked toward the resident's room to help. At approximately 3:12 PM, Employees #3 and #4 exited Resident's #8's room and the ventilator alarm was no longer activated. The call bell light above the resident's room was off and Employee #3 stated, "the resident was fine, and I reattached the tubing to the trach [tracheostomy] collar." At approximately 3:15 PM, Employee #5 returned with the nurse assigned to the resident.

A face-to-face interview was conducted on 10/19/23 AT 3:16 PM immediately after Employees #3 and #4 exited Resident #8's room. Employees #3, #4 and #5 were asked why there was no response to the initial call for assistance. Employee #5, who was found seated at the nurse's station when the call bell was activated, stated, "I went to find the nurse" then walked away. Employees #3 and #4 both stated, "we were in another resident's room." They were then asked why they did not respond to the high-pitched ventilator alarm as they walked toward the nurse's station instead of going to sit at the table behind the nurse's station and they

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both stated, "sometimes it quickly alarms and then stops when they are getting trach (tracheostomy) care, or they may be doing something else that makes it (ventilator) go off." When asked how would they know if tracheostomy care is being provided to the resident if they didn't go to assess why the ventilator alarm was ringing? Employee #3 stated, "it always ring, but if it keeps ringing we go in to see what is wrong." Employee #3 was asked why there was no response when the alarm was continuously ringing? Employee #3 stated, "I went there as soon as you told me what happened." When asked why there was no urgency to go straight to the room instead of going to sit down at the table behind the nurse's station and Employees #3 and #4 had no response. Employees #3 and #4 were asked what the Red call light means, and they both stated, "it's urgent for someone to go in the room right away."

A face-to-face interview was conducted on 10/20/23 AT 10:45 AM with Employee #6 (RT, Respiratory Therapist) who stated, "We (Respiratory Therapists) secure the HME (heat moisture exchange) with a string tied around the tubing that attaches to the tracheostomy. It's really no other way to make the connection snug due to the way the manufacturer makes the HME. The moisture from the Resident's secretions makes the HME slide on the tubing and the connection can become loose. The HME is changed as needed. We change the tubing every shift. It is a part of the resident's regular [respiratory] care. The RT's [Respiratory Therapists] are always on the floor with other residents or in the office. Answering the alarms is a joint effort from the RT's and the nurses. The

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machines are sensitive to movement from the resident, and they beep a lot, but most of the time they will stop. If the machine [ventilator] beeps once for 30 seconds to 1 minute we may not come right away, but if the machine beeps more than once or for longer than a minute, we respond right away."

A face-to-face interview was conducted on 10/20/23 AT 11:40AM with Employee #2 (DON, Director of Nursing) who stated, "Everybody can respond to a call light including EVS (Environmental Service) staff and based on the need, if the person who initially responded is not qualified to assist, then they get the appropriate staff to assist the resident. If it's suctioning the RT or RN can suction, but not the CNA or EVS. The Red light means it's an emergency and any staff who sees or hears the alarm must go in the room immediately to assess the resident, to see what's needed and tell someone else if they can't do it. I give ongoing education on answering the call light, they all should know it."

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L 000	Initial Comments An unannounced Complaints/Facility Reported Incidents (FRI) Survey was conducted at this facility from October 11, 2023, to October 20, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 105 and the survey sample included eleven (11) residents. The following Complaints were investigated: DC~10623, DC~11263, .DC~11728, DC~11891, DC~11954 and DC~12321, The following Facility Reported Incidents were investigated: DC~11870, DC~12296, DC~12402, and DC~12378 After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. Citations are being cited for: DC~11870 and DC~11263. 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	L 000		

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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
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

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L 000	Continued From page 2 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 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	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;	L 051	Corrective action 1) Resident # 3 care plan was update on 11/16/23 to include interventions as documented by psych NP on 5/9/2023	

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L 051	Continued From page 3 (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff and resident interviews for (1) of eleven sampled residents, facility staff failed to ensure that a charge nurse updated and revised Resident #3's care plan approaches after the Resident had another verbal altercation with a second resident (Resident #5). The findings included: 1. Resident #7 and Resident #3 had a verbal altercation on 04/09/23. A. Resident #7 was admitted to the facility on 09/28/21 with diagnoses including Cerebral Palsy, Type 2 Diabetes Mellitus, Chronic Respiratory Failure, Tracheostomy, Gastrostomy, Psychotic Disorder, Depression, Anxiety, and Bipolar Disorder. Review of Resident #7's medical record revealed the following: An Admission Minimum Data Set (MDS) assessment dated 10/05/21 showed that facility staff coded the Resident as having a Brief	L 051	Identify other residents. 2) All residents involved in allegations of abuse self-report could be affected. Care plans for self-reports completed in the last 30 days prior to survey will be audited by the Director of Nursing or designee to ensure that their care plan related to abuse was updated for each incident. Any deficiencies will be corrected. Systemic Changes 3) Regional Director of clinical operations will in-service the Director of Nursing on ensuring that care plans related allegation of abuse is updated for each incident. Nurse The Director of Nursing will in-service Nurse Managers and Nurse Supervisors on ensuring that care plans related to allegation of abuse self-reports are updated for each incident. Any deficiencies will be corrected. Monitoring corrective action 4) The Director of Nursing will audit care plans related to allegations of abuse self-reports to ensure that they are updated for each incident weekly x 3 months. All findings will be reported monthly to the QAPI committee for (3) consecutive months for recommendations, monitoring and education as needed. Date correction was completed. 1) Date of compliance will be November 27th 2023	

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L 051	Continued From page 4 Interview for Mental Status (BIMS) Summary Score of, "8," indicating the Resident had moderately impaired cognition. In addition, facility staff coded the Resident as rejecting care and having verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) for 1-3 days of the assessment. The Resident was coded as totally dependent on staff for mobility, requiring extensive assistance for all other ADLs (assisted daily living skills - grooming, dressing, personal hygiene, transfer. A physician's order dated 02/14/23 at 9:00 PM directed: "Diphenhydramine HCl Capsule 25 mg. Give one (1) capsule by mouth at bedtime for Anxiety." A physician's order dated 03/02/23 at 9:00 PM, directed: "Quetiapine Fumarate Tablet 25 mg. Give 25 mg by mouth two times a day for Bipolar D/o (disorder)." A Psych Progress Note dated 03/07/23 documented: "Chief complaint: follow-up on medication changes, mood, and behavior: 1. Seroquel started last week due to agitation, and mom reported Bipolar hx (history). 2. off Olanzapine x 2 weeks r/t (related to) possible adverse effects ..." B. .Resident #3 was admitted to the facility on 12/16/22 with diagnoses including Chronic Respiratory Failure, Encounter for Attention to Gastrostomy, Perforation of Esophagus, Esophageal Obstruction, and Pyothorax Without Fistula.	L 051		

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L 051	Continued From page 5 Review of Resident #3's medical record revealed the following: A physician's order dated 12/19/22 at 12:00 AM directed "Dilaudid Tablet 2 MG (Hydromorphone HCl). Give two (2) tablets via G-Tube every 4 hours for pain." A physician's order dated 03/12/23 directed: "Trazadone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet via G-Tube at bedtime for Depression and insomnia." A Quarterly Minimum Data Set (MDS) assessment dated 03/25/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "15," indicating the Resident had intact cognition. In addition, Resident #3 was coded as having no indicators of psychosis or behavioral symptoms and used no mobility device to ambulate. A Department of Health (DOH) Complaint/Incident Report Form dated 04/10/23 at 7:56 PM documented: "At approximately 4:00 PM on 04/10/23, Resident [Name of Resident who witnessed incident] reported to the 5th Floor Unit Manager that on April 9th, 2023, at around midafternoon that [pronoun] witnessed [Resident #3] verbally abusing [Resident #7]. [Pronoun] heard [Resident #3] using the word, 'what the F- is wrong with you, no gives(s) an F- about you and nobody cares about you'. It was also reported by [Resident who witnessed incident] that [Resident #7] started talking to herself and appeared distressed. Dr. Fritzner was made aware at 6:17 pm, new order for Psych consults for both patients ..."	L 051		

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L 051	Continued From page 6 A care plan initiated on 04/10/23 documented: "Focus [Resident #3] is/has potential to be verbally aggressive r/t (related to) poor impulse control. Goal: [Resident #3] will demonstrate effective coping skills through the review date. Interventions: Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; [Resident #3] was educated to keep a distance from [Resident #7] and refrain from using profanity towards resident/other resident; [Resident #3] 's triggers for verbal aggression are (another residents behavior); [Resident #3] 's behavior is de-escalated by him walking away; Psychiatric consult as indicated; When [Resident #3] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later." A Department of Health (DOH) Complaint/Incident Report Form dated 04/14/23 at 1:26 PM documented: "This is a follow-up on the report, submitted on 04/10/2023 regarding witnessed Resident-to-Resident Verbal Abuse ...Based on staff and resident interview, and eyewitness account of [Resident who witnessed incident]. [Resident #7] and [Resident #3] did have a verbal altercation. Investigation was able to substantiate a verbal altercation between two residents. [Resident #3] was educated to refrain from using profanity and informed to keep a distance from [Resident #7] during [pronoun] episodes of verbal outbursts. [Resident #3] was also encouraged to notify staff if [pronoun] had any concerns with other residents or staff..."	L 051		

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L 051	Continued From page 7 2. Residents #5 and # 3 had a verbal altercation on 05/08/23. A. Resident #5 was admitted to the facility on 07/07/22 with diagnoses including Metabolic Encephalopathy, Chronic Respiratory Failure, Hemiplegia, Muscle Weakness, Adjustment Disorder with Mixed Anxiety and Depressed Mood. Review of Resident #5's medical record revealed the following: A physician's order dated 08/18/22 directed: "Quetiapine Fumarate 25 mg. Give 0.5 mg tablet by mouth every 12 hours for Psychosis." A physician's order dated 04/14/23 directed: "Psych consult for anxiety." A Quarterly Minimum Data Set (MDS) assessment dated 02/06/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "12," indicating the Resident had mildly impaired cognition and the Resident had no indicators of psychosis or behavioral symptoms. A care plan initiated on 05/08/23 documented: "Focus - Verbal aggression received from [Resident #3] on 05/07/2023. Goal: [Pronoun] will feel save (safe) through the review date. Interventions: - [Pronoun] was educated to talk to staff if [Pronoun]has any concern; [Pronoun] verbalized understanding;" B. Resident #3 was admitted to the facility on 12/16/22 with diagnoses including Chronic Respiratory Failure, Encounter for Attention to	L 051		

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L 051	Continued From page 8 Gastrostomy, Perforation of Esophagus, Esophageal Obstruction, and Pyothorax Without Fistula. Review of Resident #3's medical record revealed the following: A physician's order dated 12/19/22 at 12:00 AM directed "Dilaudid Tablet 2 MG (Hydromorphone HCl). Give two (2) tablets via G-Tube every 4 hours for pain." A physician's order dated 03/12/23 directed: "Trazadone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet via G-Tube at bedtime for Depression and insomnia." A Quarterly Minimum Data Set (MDS) assessment dated 03/25/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "15," indicating the Resident had intact cognition. In addition, Resident #3 was coded as having no indicators of psychosis or behavioral symptoms and used no mobility device to ambulate. A Department of Health (DOH) Complaint/Incident Report Form dated 05/08/23 at 4:57 PM documented: "The Charge Nurse heard Resident #3 screaming at Resident #5 in the hallway, stating '[expletive], shut up. 'Upon interview with Resident #3, [Pronoun] explained that Resident #5 was sitting on the couch in front of the elevator saying the "F "word to no one. When Resident #5 saw Resident #3, [Pronoun] followed [Pronoun] to come sit down on the couch. Resident#3 then said to Resident #5, 'Leave me alone.' Resident #3 denied cursing at Resident #5. The charge nurse separated them.	L 051		

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L 051	Continued From page 9 Resident #3 was assured of safety and informed of [other] Resident's rights to move around the facility. [Resident #3] was also educated to refrain from using profanity and to talk to staff if [Pronoun] has any concerns ...The couch was removed. [Physician' Name], the Psychiatrist made aware of Resident #3's verbal altercation with another resident ..." A Revised Care plan dated 05/08/23 documented: " ...Interventions: [Resident # 3] had a verbal altercation with another resident on the 5th floor on 05/07/2023; [Psychiatrist Name] made aware of [Resident #3] 's verbal altercation with another resident. Presently [pronoun] is on Psych case load due to diagnoses of Anxiety Disorder, Depression, and History of Psychoactive Substance Abuse; [Physician Name] made aware on 05/08/2023. [Resident #3] is responsible for self; Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; [Resident #3] 's triggers for verbal aggression are (another residents behavior); [Resident #3] 's behavior is de-escalated by him walking away; Psychiatric consult as indicated; When [Resident #3] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later." Review of Resident #3's medical record lacked documented evidence that facility staff updated the Resident's care plan interventions after the Resident had a second verbal altercation. During a face-to-face interview on 10/20/23 at 12:45 PM, when asked about updating Resident #3's care plan after the second verbal altercation	L 051		

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L 051	Continued From page 10 with a resident, Employee #2 /Director of Nursing stated, "We may have missed it," and she acknowledged the finding. [Cross-over Ftag 657]	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3)Participate in meaningful social and	L 052	Corrective action 1) Resident # 8 call light was responded to by staff at 3:12 pm on 10/19/2023 and his vent HME tubing was placed correctly by charge nurse to ensure that the resident is receiving warm and humidified air in the respiratory tract. Resident # 8 did not suffer any adverse effects.	

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L 052	Continued From page 11 recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review and staff interviews of (1) of eleven sampled residents, facility staff failed to provide prompt response to an activated call bell when a resident required immediate assistance. (Resident #8). The findings included: Resident #8 was admitted to the facility on 02/11/21 with multiple diagnoses that included: Chronic Respiratory Failure, Tracheostomy, Ventilator Dependent, Dementia, Anxiety, Cerebral Vascular Accident with Left Hemiparesis, Sigmoid Volvulus, Bowel Resection, Gastrostomy, Congestive Heart Failure and Morbid Obesity. A Physician order dated 02/11/21 documented, "Trach (tracheostomy) care and suctioning q (every) shift and PRN (as needed) by Nursing/RT (Respiratory Therapist)." A Care Plan focus area dated 09/07/21 documented, "[Resident's name] has an ADL	L 052	Identifying other Residents 2) All residents on the 6th floor with ventilators have the potential to be affected. Residents on ventilators on the 6th floor were checked by the director of nursing on 10/19/23 and all had their HME tubing connected properly receiving warm and humified air. No other residents had their red flashing light to indicate the need for assistance with their ventilator. All residents in the facility have the potential to be affected related to call light not been responded to timely. The director of nursing chooses one room on each floor turned on the light to assess timely response to call light, all call lights were responded to within 5-10minutes on 10/19/2023. Any deficiencies will be corrected.	

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L 052	Continued From page 12 self-care performance, incontinence deficit r/t (related to) Dementia, Hemiplegia, Impaired balance." An Annual Minimum Data Set (MDS) Assessment dated 09/03/22 documented, the facility staff coded a Brief Interview for Mental Status (BIMS) score of '15,' indicating the resident was cognitively intact and functional status documented, 2-person assistance for bed mobility, transfer and toilet use. A Complaint # 11263 dated 11/28/22 AT 12:31 PM documented, "[Resident's name] is a resident at [Facility's name]" and "On 11/25/22, says that she rang the call light several times and it went unanswered for several hours." A Call Bell Assessment Questionnaire dated 09/29/23 documented, "Is the resident oriented to person? Yes; Is the resident oriented to environment? Yes; Is the resident able to verbalize their needs? No; Is the resident able to reach call bell system? Yes; Is the resident able to use call bell device on command? Yes." A Physician order dated 09/30/23 documented, "Vent (ventilator) settings: tv (tidal volume) 450 - fio2 (fraction of inspired oxygen) 30% - rate 15 - peep (positive end-expiratory pressure) 5 every shift for resp (respiratory) failure." During an observation conducted on 10/19/23 AT 10:35 AM, Resident #8, a ventilator-dependent resident, was lying in bed watching TV, tracheostomy intact and collar in place and was self-suctioning oral secretions. On 10/19/23 AT 2:55 PM the State Surveyor returned to Resident #8's room and asked the	L 052	Systemic Changes 3) Regional Director of clinical operations will in-service the Director of Nursing on ensuring that care plans related allegation of abuse is updated for each incident. Nurse The Director of Nursing will in-service Nurse Managers and Nurse Supervisors on ensuring that care plans related to allegation of abuse self-reports are updated for each incident. Any deficiencies will be corrected. Monitoring corrective action 4) The Director of Nursing will audit care plans related to allegations of abuse self-reports to ensure that they are updated for each incident weekly x 3 months. All findings will be reported monthly to the QAPI committee for (3) consecutive months for recommendations, monitoring and education as needed. Date correction was completed. 1) Date of compliance will be November 27th 2023	

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L 052	Continued From page 13 resident to activate the call bell device to observe the staff's response for assistance. At 3:03 PM there was still no response to the call for help. The State Surveyor then checked to see if the call light above the resident's room door was illuminated and found that the White call light was on. At approximately 3:05 PM, the resident's head turned to look down to grab the oral suctioning tubing, and then the HME (heat moisture exchange) tubing dislodged from tracheostomy collar and the ventilator unit alarmed then stopped. When that happened, the State Surveyor went back to the door to look for nursing staff or respiratory staff and approximately 15-20 seconds later, the ventilator unit started to alarm continuously. The call light above the resident's room door had started flashing Red and the ventilator alarm could be heard in the hallway. The State Surveyor looked out in the hall again to find facility staff and there were no staff seen in the hallway. The State Surveyor proceeded to walk approximately 20 feet to the front desk/nurse's station and observed Employee #5 (CNA, Certified Nursing Assistant) sitting at the desk in front of the Resident call bell notification device that indicated Resident #8's room number and "Vent Assistance" flashing Red. The State Surveyor explained what happened and asked Employee #5 if [pronoun] was aware that the resident needed assistance. Employee #5 stated, "I will go find the nurse" then walked away from the nurse's station to find the assigned nurse. The State Surveyor turned to walk with Employee #5 and saw two nursing staff, Employee #3 (RN, Registered Nurse) and Employee #4 (RN, Registered Nurse), walking from the other end of the hallway towards the nurse's station where the State Surveyor was standing. They did not go to the room where the light was flashing Red to	L 052		

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L 052	Continued From page 14 assess why there was a continuous high-pitched alarm. They went to an area behind the nurse's station, sat down at a desk and started to talk amongst themselves. The State Surveyor approached them at approximately 3:09 PM, explained what happened and asked if they would assist the resident. At that point, they stood back up and walked toward the resident's room to help. At approximately 3:12 PM, Employees #3 and #4 exited Resident's #8's room and the ventilator alarm was no longer activated. The call bell light above the resident's room was off and Employee #3 stated, "the resident was fine, and I reattached the tubing to the trach [tracheostomy] collar." At approximately 3:15 PM, Employee #5 returned with the nurse assigned to the resident. A face-to-face interview was conducted on 10/19/23 AT 3:16 PM immediately after Employees #3 and #4 exited Resident #8's room. Employees #3, #4 and #5 were asked why there was no response to the initial call for assistance. Employee #5, who was found seated at the nurse's station when the call bell was activated, stated, "I went to find the nurse" then walked away. Employees #3 and #4 both stated, "we were in another resident's room." They were then asked why they did not respond to the high-pitched ventilator alarm as they walked toward the nurse's station instead of going to sit at the table behind the nurse's station and they both stated, "sometimes it quickly alarms and then stops when they are getting trach (tracheostomy) care, or they may be doing something else that makes it (ventilator) go off." When asked how would they know if tracheostomy care is being provided to the resident if they didn't go to assess why the ventilator alarm was ringing? Employee #3 stated, "it always ring, but if it keeps ringing we go	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 052	Continued From page 15 in to see what is wrong." Employee #3 was asked why there was no response when the alarm was continuously ringing? Employee #3 stated, "I went there as soon as you told me what happened." When asked why there was no urgency to go straight to the room instead of going to sit down at the table behind the nurse's station and Employees #3 and #4 had no response. Employees #3 and #4 were asked what the Red call light means, and they both stated, "it's urgent for someone to go in the room right away." A face-to-face interview was conducted on 10/20/23 AT 10:45 AM with Employee #6 (RT, Respiratory Therapist) who stated, "We (Respiratory Therapists) secure the HME (heat moisture exchange) with a string tied around the tubing that attaches to the tracheostomy. It's really no other way to make the connection snug due to the way the manufacturer makes the HME. The moisture from the Resident's secretions makes the HME slide on the tubing and the connection can become loose. The HME is changed as needed. We change the tubing every shift. It is a part of the resident's regular [respiratory] care. The RT's [Respiratory Therapists] are always on the floor with other residents or in the office. Answering the alarms is a joint effort from the RT's and the nurses. The machines are sensitive to movement from the resident, and they beep a lot, but most of the time they will stop. If the machine [ventilator] beeps once for 30 seconds to 1 minute we may not come right away, but if the machine beeps more than once or for longer than a minute, we respond right away." A face-to-face interview was conducted on 10/20/23 AT 11:40AM with Employee #2 (DON,	L 052		

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L 052	Continued From page 16 Director of Nursing) who stated, "Everybody can respond to a call light including EVS (Environmental Service) staff and based on the need, if the person who initially responded is not qualified to assist, then they get the appropriate staff to assist the resident. If it's suctioning the RT or RN can suction, but not the CNA or EVS. The Red light means it's an emergency and any staff who sees or hears the alarm must go in the room immediately to assess the resident, to see what's needed and tell someone else if they can't do it. I give ongoing education on answering the call light, they all should know it."	L 052		