STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	C 01/09/2023

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F 000	INITIAL COMMENTS	F 000	Sibley Memorial Hospital Renaissance is filing the following plan of correction for the purposes of regulatory compliance. The facility is submitting this plan of corrections to comply with the applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies.	

An unannounced Recertification Survey was conducted at this facility on January 4, 2023 to January 9, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census for the survey was 12 and the survey sample included 16 residents.

The following complaints were investigated during this survey: DC00010517 and DC00010872.

The following Facility Reported Incidents were investigated during this survey: DC00010459, DC00010586, DC00010740, DC00010869, and DC00011255.

Federal and/or Local deficiencies were cited related to the investigation(s) of : DC00010459, DC 00010586, DC00010740, DC00010869 and DC00010872.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jessica Barron NHA | Administrator, Sibley Renaissance | 2/24/2023

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

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F 000	Continued From page 1	F 000		

CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological

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F 000	Continued From page 2 NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578	**F 578 Advanced Directives** 1. The advance directive for resident #79 was signed and dated January 9, 2023. This resident was discharged on 1/11/23. 2. All residents have the potential to be affected. Corrective action taken: a. Charts were reviewed and there were no other residents impacted by this deficient practice.	

			3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. Director of Case Management will provide education to the Case Management team regarding advanced directives i. Including the importance of having a signature and date on advanced directives 4. Plan for monitoring performance/sustainability: a. The Director of Case Management or a designee will perform a monthly audit on advanced directive compliance b. Results of the audit will be reported in the monthly QAPI meeting until there is 100% compliance for a consecutive 3 months. c. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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F 578	Continued From page 3 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 16 sampled residents, facility staff failed to offer a resident or their representative the right to formulate or refuse an Advanced Directive (AD). Resident #79. The findings included: Resident #79 was admitted to the facility on 12/20/22 with diagnoses that included	F 578		

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F 578	Continued From page 4 Osteoarthritis, Osteoporosis, Chronic Pain Syndrome, Right Hip Pain, and Obesity. Review of Resident #79's medical record revealed the following: Review of the Resident's Face Sheet revealed that the resident had a legal guardian. An Admission Minimum Data Set (MDS), dated 12/27/22, showed facility staff coded the resident as having a Brief Interview for Mental Status score of "15," indicating intact cognition. Resident #79's electronic medical record documented, "Advance Directives - Living Will - Patient has [an] advance directive. Copy in [physical] Chart." Review of Resident #79's physical chart showed that there were no documents filed under the "Advance Directive" tab. During a face-to-face interview on 01/06/23 at 9:12 AM, Employee #5 (Unit Manager) acknowledged that there was no documented evidence that facility staff offered Resident #79 or their legal guardian the opportunity to formulate or refuse Advanced Directives. DCMR 3231.12(r)	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584	**F 584 – Safe / Clean / Comfortable/ Homelike Environment** 1. Immediate action: a. Bathroom vents in rooms 322, 327, 328, and 330 were cleaned on January 5, 2023. b. Plastic was mounted over areas of chipped paint in rooms 322, 327, and 330. 2. All residents have the potential to be	

			affected. Corrective action taken: a. All bathroom vents were cleaned on January 5, 2023. b. There were no residents negatively impacted from this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. Director of Plant Operations will provide Education to the plant operations team regarding LTC regulations i. Including bathroom vents being dust free ii. Rooms being free of peeling paint 4. Plan for monitoring performance/sustainability: a. Room audits will be completed monthly by Plant Operations Director or designee i. Paint integrity and vent cleanliness will be tracked b. Results of the audit will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months. c. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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F 584	Continued From page 5 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services	F 584		

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F 584	Continued From page 6 necessary to maintain a safe, clean, comfortable environment as evidenced by soiled bathroom vents in four (4) of eight (8) resident's rooms, and walls marred with peeling paint in three (3) of eight (8) resident's rooms. The findings include: During an environmental walkthrough of the facility on January 4, 2023, at approximately 3:15 PM, the following were observed: • Bathroom vents were soiled on the inside and outside in four (4) of eight (8) resident's rooms including rooms #322, #327, #328, and #330. • Paint was peeling from the walls in three (3) of eight (8) resident's rooms (#322, #327, #330). These findings were acknowledged by Employee #8 on January 4, 2023, at approximately 4:00 PM.	F 584		
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	F 607	**F607 –Abuse/Neglect Policy** 1. Immediate: There are no further corrective actions for this deficient practice as the residents involved have been discharged. Resident 80 was discharged on 6/16/22, Resident 85 was discharged on 7/6/22 and Resident 81 was discharged on 12/2/21. 2. All residents have the potential to be affected/ corrective action taken: a. Residents impacted by this deficient practice are identified when there is a reportable incident related to an allegation of abuse, neglect, exploitation, or mistreatment at the facility – including an injury of unknown origin. b. There were no active incidences at the time of the survey or at the time this POC is being written. 3. Systemic changes that will be made to ensure deficient practice does not reoccur:	

			a. Resident Abuse and Neglect Policy will be reviewed by the Administrator to ensure compliance with state and federal requirements. b. Administration to provide education to DON on the Resident Abuse and Neglect Policy REN 001- including required reporting time frames and investigating process. c. Tracking log for incident reporting updated by Administrator to include a checklist of required steps for reporting and investigating allegations of abuse, neglect, and falls. d. Administrator will educate nursing staff on reporting and investigation requirements for allegations of abuse, neglect, and falls. 4. Plan for Monitoring performance/sustainability: a. Incidents from the month prior will each be reported and reviewed in the monthly QAPI meeting b. Administrator will conduct monthly audits for 3 months to ensure compliance with the abuse and neglect policy for timely reporting and investigation of incidents. i. Compliance will be reported monthly at each QAPI meeting until 100% compliance is sustained for 3 months. ii. Any identified instances of non-compliance will be addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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F 607	Continued From page 7 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 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 and staff interviews, for three (3) of 16 sampled residents, facility staff failed to implement its policies and procedures for reporting and investigating incidents involving abuse, neglect, and injuries of unknown origin. Residents' #81, #80 and #85. The findings included: Review of the "Abuse and Neglect Policy" with an effective date of 12/23/21, documented, "...The Director of Nursing (DON) shall be notified in order to assist in appropriately implementing the notification requirements ... incidents of abuse ...shall be reported to the DC (District of Columbia) Metropolitan Police, the Long-Term Care Ombudsman, and Adult Protective Services: within 2 hours after the allegation has been made if the event(s) that caused the allegation involve(s) abuse ...Investigation ... All reports of alleged abuse, misappropriation of property, and injuries of unknown origin are investigated	F 607		

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F 607	Continued From page 8 promptly in a systematic and thorough manner ... The facility shall report the results of all investigations to the Administrator or his/her designated representative and to other officials in accordance with DC law, including the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken..." 1. Facility staff failed to follow their policy to investigate a potential allegation of neglect involving Resident #81's witnessed fall with injury and failed to report it to State Agency in the required timeframe. Resident #81 was admitted to the facility on 12/02/21 with multiple diagnoses that included: Unspecified Fall, Hypertension, and Benign Prostatic Hyperplasia (BPH). Review of a Facility Reported Incident (FRI), DC00010459, submitted to the State Agency on 12/16/21, showed, "...Date 12/10/21 Time 1730 (5:30 PM) At 1730H (5:30 PM) Resident requested to be transferred from chair to bed. The patient care tech (technician) (PCT) assisted the resident gait belt in place and help the resident stand and move the chair to give space for resident to turn, after standing started to sit so the PCT assisted the resident to the floor. According to the resident, he thought that the chair is still at the back ...RN (registered nurse) assessed resident vital sign (Sp) was stable and treated the small abrasion on the left upper shoulder ..." A review of Resident #81's medical record revealed the following:	F 607		

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F 607	Continued From page 9 An Admission Minimum Data Set (MDS) dated 12/09/21, showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15", which indicates intact cognition; required two-person physical assistance for transfers; used a walker for mobility; and had fall in the last one (1) to six (6) months prior to admission. 12/10/21 [Physician's Order] "CT (computed tomography) Head/Brain WO (without) Contrast Order ...stat ..." 12/10/21 at 5:30 PM, the "Post Fall Safety Huddle" showed facility staff placed a checkmark in the section that stated, " ...All falls must be reported to the DOH (Department of Health) ..." to indicate that the incident was reported. 12/10/21 at 8:20 PM [Nurse's Note] "...At 1730 (5:30 PM) pt (Patient) had incident, assisted fall when transferred him from chair to bed. After notified to his provider ...Pt sent to CT (computed tomography) scan (no Hemorrhage, Mass lesion, Acute infarction). Patient denied pain and has skin abrasion on left upper shoulder ..." 12/13/21 at 5:57 PM [Physician's Note] "...CT of the head WO (without) contrast showed no acute intracranial pathology ..." The evidence showed that the facility's staff did not report the fall incident that occurred on 12/10/21 to the State Agency until 12/16/21, seven (7) days later and there was no documented evidence that an investigation into the fall incident had been conducted by the facility's staff.	F 607		

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F 607	Continued From page 10 The medical record lacked documented evidence that the facility staff conducted a thorough investigation into Resident #81's witnessed fall with staff as evidenced by: no statement from the PCT present at the time of the fall; and no resident interview. During a face-to-face interview conducted on 01/09/23 at 3:14 PM, Employee #2 (Director of Nursing) stated, "I have no record of it (Facility incident investigation)." 2. Facility staff failed to follow their policy to investigate injuries of unknown origin as evidenced by failing to investigate Resident #80's injury of unknown origin which occurred on 05/12/22. Resident #80 was admitted to the facility on 04/21/22 with multiple diagnoses that included: Hypertension, Dislocation of Internal Right Hip Prosthesis, Presence of Left Artificial Hip Joint, and Infection and Inflammatory Reaction. Review of a facility-reported incident (FRI), DC00010740, submitted by the facility to the State Agency on 05/13/22 documented, "...5/12/22 Time: 0515 (5:15 AM) ...At around 0515 (5:15) CNA (Certified Nurse Aide) called the attention of the assigned nurse to resident, she stated that the resident was having pain. Interpreter was called. Resident related to interpreter that when she got up with the help of the CNA to go to the bathroom she felt as if her hip was out of place. Resident was assessed. Hip abductor brace was in placed (sp) but noted that the legs are uneven ...The Charge nurse was informed and ...called the on-call doctor ...order	F 607		

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F 607	Continued From page 11	F 607		

was written and carried out, X-ray (X radiation) of rt (right) hip and pelvis was done, result was hip arthroplasty dislocation ..."

A review of Resident #80's medical record revealed the following:

An Admission MDS dated 04/28/22, showed that the facility staff coded: preferred language as Spanish to communicate; a Brief Interview for Mental Status summary score of "15", indicating intact cognition; needed limited assistance requiring one-person physical assistance from staff for bed mobility, transfer, walk-in room, toilet use, and personal hygiene; and the resident was coded as using a walker.

05/12/22 at 9:43 AM [Physician's Note] " ...Contacted by RN (Registered Nurse) at 7:45 AM that patient is concerned that her right hip has dislocated again RN also confirms that her leg length is uneven. I contacted the Ortho resident who requested Xrays of hip and pelvis. Xrays ordered stat (immediately). At 9:10am - I have been contacted by the Radiologist, patient does in fact have a dislocation ...asked for patient to be transferred to the ER (emergency room) promptly..."

05/13/22 at 10:52 AM [Physician's Assistant Note] "...Use of language line interpreter ...to interview patient. Patient states she woke up yesterday morning and asked for assistance to restroom. As she was ambulating noted that her Right leg felt much shorter than her left it may be dislocated. She denies any difficulty ambulating earlier in the day and denies any occurrence of a sharp pain or a "pop" in that hip. ..She was subsequently sent to the ED (Emergency

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	095030	A. BUILDING _____ B. WING _____	C 01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

(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 12 Department) and it was reduced by the orthopedic resident under conscious sedation..." A review of the facility's incidents binder and investigation documents lacked documented evidence that the facility investigated Resident #80's injury of unknown origin. During a face-to-face interview conducted on 01/09/23 at 3:19 PM, Employee #2 (Director of Nursing) stated "I am not aware of a reason why we did not complete an investigation." 3. Facility staff failed to report an alleged incident of staff-to-resident verbal abuse between Resident #85 and Employee #11 to the State Agency within the required timeframe per the facility's Abuse policy. Resident #85 was re-admitted to the facility on 07/06/22 with diagnoses including Acute and Chronic Pain, Type 2 Diabetes, Diabetic Neuropathy and Anxiety Disorder. Review of Resident #85's medical record revealed: A face sheet that showed Resident #85 resided in room 306. A 5-Day Assessment dated 07/13/22 showed that facility staff coded: a Brief Interview for Mental Status Summary Score of "15", indicating intact cognition; no rejection of care and was almost always in pain. 07/07/22 [Physician's Order]: "Hydromorphone (Dilaudid) (narcotic pain medication) Take 1 tablet	F 607		

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F 607	Continued From page 13	F 607		

8 mg (milligrams) total by mouth every 6 hours as needed for pain (severe pain)."

07/07/22 [Physician's Order]: "Zolpidem (Ambien) (narcotic sleeping medication) 12.5 mg CR (controlled release) tablet. Take 12.5 mg by mouth nightly as needed for sleep."

07/08/22 at 7:32 AM [Nurses Progress Note written by Employee #11]: "Late entry for care provided on the 7th July 2022 - Assumed care of [Resident #85] at 7 PM 7/7/2022. Patient was met sitting in bed watching TV (television), was assisted throughout the night, and medicated for pain and Ambien for sleep; she requested another dose of 8 mg (milligrams) of Dilaudid and was reminded that it was too early for another dose of Dilaudid ...She was not happy...but reluctantly accepted the message and went back to sleep at bedtime ..."

07/12/22 at 1:41 PM, a Facility Reported Incident (FRI), DC00010859, received by the State Agency documented, "... [Resident #85] alleges that on Friday, July 8th during the night shift (7p-7a), she was confronted by an RN (Registered Nurse) in her room who said, "Do you have a problem with me." The patient was uncomfortable with this interaction and was concerned she wouldn't receive proper care. The RN in question was not assigned to this Resident at the time of the alleged verbal confrontation..."

07/12/22 at 3:07 PM [Nurses Progress Note/Late Entry]: "This writer met with [Resident #85] at her request on 07.09.2022. [Resident #85] expressed to me an unpleasant interaction she had with an RN. Her perception was that RN was not caring and responsive to her pain med needs ...At the

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F 607	Continued From page 14 Resident's request, the RN involved will not be assigned to her while she is in the facility ..." The evidence showed that the alleged incident between Resident #85 and Employee #11 occurred on the night shift on 07/07/22. Facility staff reported this incident to the State Agency on 07/12/22, six (6) days later. During a face-to-face interview on 01/09/23 at 2:43 PM, Employee #1 (Administrator) stated that she was not working at the facility when the incident occurred. She acknowledged that facility staff should have reported the incident between Resident # 85 and Employee #11 to the State agency immediately. DCMR - 3232.4	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 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	F 609	**F609 – Reporting of Alleged Violations** 1. There are no further corrective actions for this deficient practice as the residents involved have been discharged home. Resident 80 was discharged on 6/16/22, Resident 85 was discharged on 7/6/22 and Resident 81 was discharged on 12/2/21. 2. All residents have the potential to be affected/ corrective action taken: • Residents impacted by this deficient practice are identified when there is a reportable incident related to an allegation of abuse, neglect, exploitation, or mistreatment at the facility. • There were no active incidences at the time of the survey or at the time this POC is being written. 3. Systemic changes that will be made to ensure deficient practice does not reoccur:	

			• Administrator will educate DON on the Resident Abuse and Neglect Policy REN 001- i. including required reporting time frames • Tracking log for incident reporting will be created by Administrator to include a checklist of required steps for reporting and thoroughly investigating allegations of abuse, neglect, and falls. • Administrator will educate the nursing team on timely reporting and investigation requirements for allegations of abuse, neglect, and falls. 4. Plan for Monitoring performance/sustainability: • Administrator will conduct monthly audits for 3 months to ensure compliance with the abuse and neglect policy for timely reporting and investigation of incidents. i. Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. ii. Any identified instances of non-compliance will be addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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F 609	Continued From page 15 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 review of facility records, reported incidents, policies, and staff interview for four (4) of 16 sampled residents, facility staff failed to report the following incidents to the state agency in the required timeframes for one (1) resident who had a witnessed fall with staff that resulted in injury, one (1) residents with injuries of unknown origin, and one (1) resident with an allegation of abuse. (Residents' #81, #80, and #85) The findings included: A facility policy titled "Abuse and Neglect Policy" (Formerly 01-28-01), effective 12/23/2021, documented: " ...Procedure ...E. The Director of Nursing shall be notified to assist in appropriately implementing the notification requirements ... incidents of abuse...shall be reported to the DC Metropolitan Police, the Long-Term Care Ombudsman, and Adult Protective Services: within 2 hours after the allegation has been made if the event(s) that caused the allegation involve abuse ...Investigation:.. a. All reports of alleged abuse, misappropriation of property, and injuries of unknown origin are investigated promptly in a systematic and through manner ...e. The facility	F 609		

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F 609	Continued From page 16 shall report the results of all investigations to the Administrator or his/her designated representative and to other officials in accordance with DC law, including the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken ..." 1. Facility staff failed to report Resident #81's witnessed fall with staff that occurred on 12/10/21, to the state agency within 24 hours but instead reported the fall on 12/16/2021. Resident #81 was admitted to the facility on 12/02/21 with multiple diagnoses that included: Unspecified Fall, Hypertension, and Benign Prostatic Hyperplasia (BPH). Review of a Facility Reported Incident (FRI), DC00010459, submitted to the State Agency on 12/16/21, showed, "...Date 12/10/21 Time 1730 (5:30 PM) At 1730H (5:30 PM) Resident requested to be transferred from chair to bed. The patient care tech (technician) (PCT) assisted the resident gait belt in place and help the resident stand and move the chair to give space for resident to turn, after standing started to sit so the PCT assisted the resident to the floor. According to the resident, he thought that the chair is still at the back ...RN (registered nurse) assessed resident vital sign (Sp) was stable and treated the small abrasion on the left upper shoulder ..." A review of Resident #81's medical record revealed the following: An Admission Minimum Data Set (MDS) dated	F 609		

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12/09/21, showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15", which indicates intact cognition; required two-person physical assistance for transfers; used a walker for mobility; and had fall in the last one (1) to six (6) months prior to admission.

12/10/21 [Physician's Order] "CT (computed tomography) Head/Brain WO (without) Contrast Order ...stat ..."

12/10/21 at 5:30 PM, the "Post Fall Safety Huddle" showed facility staff placed a checkmark in the section that stated, " ...All falls must be reported to the DOH (Department of Health) ..." to indicate that the incident was reported.

12/10/21 at 8:20 PM [Nurse's Note] "...At 1730 (5:30 PM) pt (Patient) had incident, assisted fall when transferred him from chair to bed. After notified to his provider ...Pt sent to CT (computed tomography) scan (no Hemorrhage, Mass lesion, Acute infarction). Patient denied pain and has skin abrasion on left upper shoulder ..."

12/13/21 at 5:57 PM [Physician's Note] "...CT of the head WO (without) contrast showed no acute intracranial pathology ..."

The evidence showed that the facility's staff did not report the fall incident that occurred on 12/10/21 to the State Agency until 12/16/21, seven (7) days later and there was no documented evidence that an investigation into the fall incident had been conducted by the facility's staff.

During a face-to-face interview conducted on

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F 609	Continued From page 18 01/09/23 at 3:14 PM, Employee #2 (Director of Nursing) stated, "I have no record of it (Facility incident investigation). 2. Facility staff failed to report an injury of unknown origin that resulted in Resident #80's right hip dislocation within 2 hours to the state agency. Resident #80 was admitted to the facility on 04/21/22 with multiple diagnoses that included: Hypertension, Dislocation of Internal Right Hip Prosthesis, Presence of Left Artificial Hip Joint, and Infection and Inflammatory Reaction. Review of a facility-reported incident (FRI), DC00010740, submitted by the facility to the State Agency on 05/13/22 documented, "...5/12/22 Time: 0515 (5:15 AM) ...At around 0515 (5:15) CNA (Certified Nurse Aide) called the attention of the assigned nurse to resident, she stated that the resident was having pain. Interpreter was called. Resident related to interpreter that when she got up with the help of the CNA to go to the bathroom she felt as if her hip was out of place. Resident was assessed. Hip abductor brace was in placed (sp) but noted that the legs are uneven ...The Charge nurse was informed and ...called the on-call doctor ...order was written and carried out, X-ray (X radiation) of rt (right) hip and pelvis was done, result was hip arthroplasty dislocation ..." A review of Resident #80's medical record revealed the following: An Admission MDS dated 04/28/22, showed that the facility staff coded: preferred language as Spanish to communicate; a Brief Interview for	F 609		

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F 609	Continued From page 19 Mental Status summary score of "15", indicating intact cognition; needed limited assistance requiring one-person physical assistance from staff for bed mobility, transfer, walk-in room, toilet use, and personal hygiene; and the resident was coded as using a walker. 05/12/22 at 9:43 AM [Physician's Note] " ...Contacted by RN (Registered Nurse) at 7:45 AM that patient is concerned that her right hip has dislocated again RN also confirms that her leg length is uneven. I contacted the Ortho resident who requested Xrays of hip and pelvis. Xrays ordered stat (immediately). At 9:10am - I have been contacted by the Radiologist, patient does in fact have a dislocation ...asked for patient to be transferred to the ER (emergency room) promptly..." 05/13/22 at 10:52 AM [Physician's Assistant Note] "...Use of language line interpreter ...to interview patient. Patient states she woke up yesterday morning and asked for assistance to restroom. As she was ambulating noted that her Right leg felt much shorter than her left it may be dislocated. She denies any difficulty ambulating earlier in the day and denies any occurrence of a sharp pain or a "pop" in that hip. ..She was subsequently sent to the ED (Emergency Department) and it was reduced by the orthopedic resident under conscious sedation..." There was no documented evidence that the facility staff reported Resident #80's injury of unknown origin, resulting in a dislocation of the right hip to the State agency within the 2-hour required time. During a face-to-face interview conducted on	F 609		

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F 609	Continued From page 20 01/09/23 at approximately 5:00 PM Employee #2 (Director of Nursing) acknowledged the findings and stated, "There were instructions where we should call a number to DOH (Department of Health) and leave a message and that's probably what staff did." 3. Facility staff failed to immediately report an alleged incident of staff-to-resident verbal abuse involving Resident #85 on 07/08/22 to the State Agency. Resident #85 was re-admitted to the facility on 07/06/22 with diagnoses including Acute and Chronic Pain, Type 2 Diabetes, Diabetic Neuropathy and Anxiety Disorder. Review of Resident #85's medical record revealed: A face sheet that showed Resident #85 resided in room 306. A 5-Day Assessment dated 07/13/22 showed that facility staff coded: a Brief Interview for Mental Status Summary Score of "15", indicating intact cognition; no rejection of care and was almost always in pain. 07/07/22 [Physician's Order]: "Hydromorphone (Dilaudid) (narcotic pain medication) Take 1 tablet 8 mg (milligrams) total by mouth every 6 hours as needed for pain (severe pain)." 07/07/22 [Physician's Order]: "Zolpidem (Ambien) (narcotic sleeping medication) 12.5 mg CR (controlled release) tablet. Take 12.5 mg by mouth nightly as needed for sleep."	F 609		

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F 609	Continued From page 21 07/08/22 at 7:32 AM [Nurses Progress Note written by Employee #11]: "Late entry for care provided on the 7th July 2022 - Assumed care of [Resident #85] at 7 PM 7/7/2022. Patient was met sitting in bed watching TV (television), was assisted throughout the night, and medicated for pain and Ambien for sleep; she requested another dose of 8 mg (milligrams) of Dilaudid and was reminded that it was too early for another dose of Dilaudid ...She was not happy...but reluctantly accepted the message and went back to sleep at bedtime ..." 07/12/22 at 1:41 PM, a Facility Reported Incident (FRI), DC00010859, received by the State Agency documented, "... [Resident #85] alleges that on Friday, July 8th during the night shift (7p-7a), she was confronted by an RN (Registered Nurse) in her room who said, "Do you have a problem with me." The patient was uncomfortable with this interaction and was concerned she wouldn't receive proper care. The RN in question was not assigned to this Resident at the time of the alleged verbal confrontation..." 07/12/22 at 3:07 PM [Nurses Progress Note/Late Entry]: "This writer met with [Resident #85] at her request on 07.09.2022. [Resident #85] expressed to me an unpleasant interaction she had with an RN. Her perception was that RN was not caring and responsive to her pain med needs ...At the Resident's request, the RN involved will not be assigned to her while she is in the facility ..." The evidence showed that the alleged incident between Resident #85 and Employee #11 occurred on the night shift on 07/07/22. Facility staff reported this incident to the State Agency on	F 609		

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F 609	Continued From page 22 07/12/22, six (6) days later. During a face-to-face interview on 01/09/23 at 2:43 PM, Employee #1 (Administrator) stated that she was not working at the facility when the incident occurred. She acknowledged that facility staff should have reported the incident between Resident # 85 and Employee #11 to the State agency immediately. DCMR 3232.5	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 review of facility records, reported incidents, policies, and staff interviews for two (2) of 16 sampled residents, the facility's staff failed to show evidence of conducting thorough	F 610	**F610 – Investigate / Prevent/Correct Alleged Violation** 1. There are no further corrective actions for this deficient practice as the residents have been discharged home. Resident 80 was discharged on 6/16/22 and Resident 81 was discharged on 12/2/21. 2. All residents have the potential to be affected/ corrective action taken: • Residents impacted by this deficient practice are identified when there is a reportable incident related to an allegation of abuse, neglect, exploitation, or mistreatment at the facility. • There were no open incidences at the time of the survey or at the time this POC is being written. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: • Administrator will educate	

			DON on the Resident Abuse and Neglect Policy REN 001 i. Including investigation requirements • Tracking logs for incident reporting will be created by Administrator to include a checklist of required steps for reporting and thoroughly investigating allegations of abuse, neglect, and falls. • Administrator will educate nursing staff on reporting and investigation requirements for allegations of abuse, neglect, and falls. 4. Plan for Monitoring performance/sustainability: • Administrator will conduct monthly audits for 3 months to ensure compliance with the abuse and neglect policy for timely reporting and thorough investigation of incidents. i. Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. ii. Any identified instances of non-compliance will be addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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F 610	Continued From page 23 investigations for one (1) resident that had a fall with injury and one (1) resident with an injury of unknown origin. Residents' #81 and #80. The findings included: Review of the facility's policy titled " Abuse and Neglect Policy" with an effective date of 12/23/21 instructs " ...The Director of Nursing, and or Administrator or designee of the [Facility Name], will investigate all allegations as soon as they have knowledge of the event ...The facility shall report the results of all investigations to the administrator or his/her designated representative and to other officials in accordance with DC law, including the State Survey Agency, within five (5) working days of the incident and if the alleged violation is verified, appropriate corrective action must be taken ... " 1. Facility staff failed to thoroughly investigate Resident #81's witnessed fall with staff that resulted in an injury. Resident #81 was admitted to the facility on 12/02/21 with multiple diagnoses that included: Unspecified Fall, Hypertension, and Benign Prostatic Hyperplasia (BPH). Review of a Facility Reported Incident (FRI), DC00010459, submitted to the State Agency on 12/16/21, showed, "...Date 12/10/21 Time 1730 (5:30 PM) At 1730H (5:30 PM) Resident requested to be transferred from chair to bed. The patient care tech (technician) (PCT) assisted the resident gait belt in place and help the resident stand and move the chair to give space for resident to turn, after standing started to sit so the PCT assisted the resident to the floor.	F 610		

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F 610	Continued From page 24 According to the resident, he thought that the chair is still at the back ...RN (registered nurse) assessed resident vital sign (Sp) was stable and treated the small abrasion on the left upper shoulder ..." A review of Resident #81's medical record revealed the following: An Admission Minimum Data Set (MDS) dated 12/09/21, showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15", which indicates intact cognition; required two-person physical assistance for transfers; used a walker for mobility; and had fall in the last one (1) to six (6) months prior to admission. 12/10/21 [Physician's Order] "CT (computed tomography) Head/Brain WO (without) Contrast Order ...stat ..." 12/10/21 at 5:30 PM, the "Post Fall Safety Huddle" showed facility staff placed a checkmark in the section that stated, " ...All falls must be reported to the DOH (Department of Health) ..." to indicate that the incident was reported. 12/10/21 at 8:20 PM [Nurse's Note] "...At 1730 (5:30 PM) pt (Patient) had incident, assisted fall when transferred him from chair to bed. After notified to his provider ...Pt sent to CT (computed tomography) scan (no Hemorrhage, Mass lesion, Acute infarction). Patient denied pain and has skin abrasion on left upper shoulder ..." 12/13/21 at 5:57 PM [Physician's Note] "...CT of the head WO (without) contrast showed no acute intracranial pathology ..."	F 610		

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F 610	Continued From page 25 The evidence showed that the facility's staff did not report the fall incident that occurred on 12/10/21 to the State Agency until 12/16/21, seven (7) days later and there was no documented evidence that an investigation into the fall incident had been conducted by the facility's staff. The medical record lacked documented evidence that the facility staff conducted a thorough investigation into Resident #81's witnessed fall with staff as evidenced by: no statement from the PCT present at the time of the fall; and no resident interview. During a face-to-face interview conducted on 01/09/23 at 3:14 PM, Employee #2 (Director of Nursing) stated, "I have no record of it (Facility incident investigation)." 2. Facility staff failed to thoroughly investigate Resident #80's injury of unknown origin later diagnosed as a dislocation of the right hip. Resident #80 was admitted to the facility on 04/21/22 with multiple diagnoses that included: Hypertension, Dislocation of Internal Right Hip Prosthesis, Presence of Left Artificial Hip Joint, and Infection and Inflammatory Reaction. Review of a facility-reported incident (FRI), DC00010740, submitted by the facility to the State Agency on 05/13/22 documented, "...5/12/22 Time: 0515 (5:15 AM) ...At around 0515 (5:15) CNA (Certified Nurse Aide) called the attention of the assigned nurse to resident, she stated that the resident was having pain. Interpreter was called. Resident related to	F 610		

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F 610	Continued From page 26	F 610		

interpreter that when she got up with the help of the CNA to go to the bathroom she felt as if her hip was out of place. Resident was assessed. Hip abductor brace was in placed (sp) but noted that the legs are uneven ...The Charge nurse was informed and ...called the on-call doctor ...order was written and carried out, X-ray (X radiation) of rt (right) hip and pelvis was done, result was hip arthroplasty dislocation ..."

A review of Resident #80's medical record revealed the following:

An Admission MDS dated 04/28/22, showed that the facility staff coded: preferred language as Spanish to communicate; a Brief Interview for Mental Status summary score of "15", indicating intact cognition; needed limited assistance requiring one-person physical assistance from staff for bed mobility, transfer, walk-in room, toilet use, and personal hygiene; and the resident was coded as using a walker.

05/12/22 at 9:43 AM [Physician's Note] " ...Contacted by RN (Registered Nurse) at 7:45 AM that patient is concerned that her right hip has dislocated again RN also confirms that her leg length is uneven. I contacted the Ortho resident who requested Xrays of hip and pelvis. Xrays ordered stat (immediately). At 9:10am - I have been contacted by the Radiologist, patient does in fact have a dislocation ...asked for patient to be transferred to the ER (emergency room) promptly..."

05/13/22 at 10:52 AM [Physician's Assistant Note] "...Use of language line interpreter ...to interview patient. Patient states she woke up yesterday morning and asked for assistance to restroom.

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F 610	Continued From page 27 As she was ambulating noted that her Right leg felt much shorter than her left it may be dislocated. She denies any difficulty ambulating earlier in the day and denies any occurrence of a sharp pain or a "pop" in that hip. ..She was subsequently sent to the ED (Emergency Department) and it was reduced by the orthopedic resident under conscious sedation..." A review of the facility's incidents binder and investigation documents lacked documented evidence that the facility investigated Resident #80's injury of unknown origin. During a face-to-face interview conducted on 01/09/23 at 3:19 PM, Employee #2 (Director of Nursing) stated "I am not aware of a reason why we did not complete an investigation."	F 610		
F 656 SS=D	DCMR 3232.2 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 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	F 656	**F656 – Develop/ Implement Comprehensive Care Plan** **1.** The importance of resident-centered care plans is acknowledged. The Care plan for resident #3 was assessed and updated on 2/24/23 to demonstrate recent COVID-19 infection. There was no negative outcome from this deficient practice on the resident. Resident #128 was discharged from the facility on 1/25/23, there is no further action for compliance. 2. All residents have the potential to be affected/ corrective action taken: a. Resident care plans reviewed. There were no negative outcomes from this deficient practice.	

			3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. MDS coordinator to provide education to nursing staff on the importance of resident-centered care plans i. Including the change in status related to COVID-19 and polypharmacy/ >9 medications 4. Plan for Monitoring performance/sustainability: a. The Quality Compliance Nurse or designee will perform a monthly audit for the appropriateness of the care plan created on admission. b. Results of the audit will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months. c. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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F 656	Continued From page 28 (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 16 sampled residents, facility staff failed to develop and implement comprehensive person-centered care plans with goals and approaches to address one (1) resident who is prescribed nine (9) prescribed medications; and one (1) resident who contracted COVID-19. Residents' #128 and #3.	F 656		

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F 656	Continued From page 29 The findings included: 1. Facility staff failed to develop a comprehensive-person-centered care plan with goals and approaches to address Resident #128 being on nine (9) prescribed medications. Resident #128 was admitted to the facility on 12/21/22 with multiple diagnoses that included: Hypertension, Hyperlipidemia, Benign Prostatic Hyperplasia (BPH), and Hypothyroidism. Review of resident #128's medical record revealed the following physician's orders: 12/21/22 "Benzonatate (cough suppressants) ... capsule 100mg (Milligram)..." 12/21/22 "Enoxaparin (anticoagulant) ... syringe 40 mg Subcutaneous, every evening" 12/21/22 "Simvastatin (cholesterol lowering medication) tablet 5 mg oral nightly" 12/21/22 "Guaifenesin (expectorant) 12 hr (hour) tablet 600 mg oral 2 times daily" 12/21/22 "Tamsulosin (treats BPH) 24 hr (hour) capsule 0.4 mg oral daily" 12/21/22 "Polyethylene Glycol (laxative) packet 17 g oral daily" 12/21/22 "Levothyroxine (thyroid hormone supplement) tablet 88 mcg (microgram) oral every morning" 12/21/22 "Finasteride (treats BPH) tablet 5 mg	F 656		

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F 656	Continued From page 30 oral every morning" 12/24/22 "Rivastigmine (treats dementia) 4.6 mg/24-hour patch: 1 patch transdermal daily..." A review of Resident #128's medical record lacked documented evidence of a polypharmacy care plan to address the resident receiving nine (9) prescribed medications. During a face-to-face interview conducted on 01/09/23 at 4:20 PM, Employee #5 (Charge Nurse) acknowledged the findings and stated, "I don't see it [polypharmacy care plan]." 2. Facility staff failed to develop a comprehensive patient-centered care plan that included Resident #3's recent COVID-19 infection on 12/10/22. Resident #3 was re-admitted to the facility on 12/20/22 with diagnoses including a Personal History of COVID-19, Pneumonia due to COVID-19, and Unspecified Intellectual Disabilities. Review of Resident #3's medical record revealed: A 5 Day Scheduled Assessment dated 12/27/22 showed that facility staff coded: a Brief Interview for Mental Status Summary Score of "15," indicating intact cognition. 12/09/22 [Department of Health (DOH) Notice of Discharge Transfer or Relocation] form "... (1) The proposed action is transfer (2) The specific reason(s) to this section is...transfer to acute for positive COVID..." 12/20/22 [History and Physical/Physician's Note]:	F 656		

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F 656	Continued From page 31 "...had no new acute problems until 12-10-22 when he developed onset congested cough and rhinorrhea. He had repeat covid testing performed and was positive with [COVID-19] and again transferred to the main hospital Covid Unit... He returns today c/o (complaining of) a stiff neck, resolved cough, generalized weakness, and increased dependence for care ..." 12/20/22 [Care Plan]: " ...Problem: Ineffective Breathing Pattern. Start Date: 12/20/23 ...Goal: Resident's breathing pattern will be maintained. Interventions: Assess Resident for changes in orientation, increase restlessness, anxiety, and hunger...Monitor vital signs, lung sounds, and presence of secretion every shift. Notify physician for abnormal changes... Position resident with proper body alignment for optimal breathing pattern ... ...Maintain a clear airway ...Call Rapid Response for acute respiratory distress for immediate intervention ..." During a face-to-face interview on 01/06/23 at 10:38 AM, Employee #5 (Unit Manager) stated that facility staff did not include the Resident's recent COVID-19 infection and hospitalization in the Resident's comprehensive care plan."	F 656		
F 657 SS=D	DCMR 3210.4 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	**F657 – Care Plan revisions** 1. The importance of resident-centered care plans and revisions when there is a change is acknowledged. Both residents (#277 and #278) have been discharged from our facility, there is no further action for compliance. Resident # 277 was discharged on 1/17/23 and	

Resident #278 was discharged on 1/11/23.

2. All residents have the potential to be affected/ corrective action taken:

    a. Resident care plans reviewed. There were no negative outcomes from this deficient practice.

3. Systemic changes that will be made to ensure deficient practice does not reoccur:
    a. MDS coordinator to provide education to nursing staff on the importance of resident-centered care plans and revisions when there is a change
        i. Including family bringing food from outside the facility and after a resident fall
    b. Revision of resident care plan after a fall will be included on the fall reporting algorithm for charge nurse

4. Plan for monitoring performance/sustainability:
    a. The Quality Compliance Nurse or designee will perform a monthly audit for the appropriateness of the care plan created on admission and revisions when there is a change.
    b. Results of the audit will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months.
    c. Non-compliance will be tracked and addressed immediately

5. Date corrective action will be complete: March 10, 2023

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F 657	Continued From page 32 §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 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 interviews, for two (2) of 16 sampled residents, facility staff failed to revise/update the comprehensive care plan with new goals and approaches that addressed: one (1) resident's family bringing in foods from outside the facility; and one (1) resident's fall. Residents' #277 and #278. The findings included:	F 657		

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1. Facility staff failed to revise/update Resident #277's nutritional care plan to include foods brought in from outside the facility.

Policy "NUSE-GEN061" dated 11/04/20 documented, " ...Food and Nutrition Services will not serve food prepared outside the food and nutrition services ...The department of Food and Nutrition Services does not accept responsibility for patient illness resulting from foods provided by a family member or outside sources ..."

Resident #277 was admitted to the facility on 12/26/22, with multiple diagnoses that included Asthma, Congestive Heart Failure, Chronic Lymphocytic Leukemia, Hypertension, and Hyponatremia.

During an interview on 01/04/23 at 11:00 AM, Resident #277 stated, "I only eat breakfast here. My family brings in my lunch and dinner." At this time, the private aide in the resident's room and resident's daughter both confirmed this statement made by Resident #277.

Review of Resident #277's medical record revealed:

Admission MDS dated 12/26/22 showed that facility staff coded a Brief Interview for Mental Status summary score of "15", indicating intact cognition; independent for eating; active diagnosis of Gastroesophageal Reflux Disease (GERD), or Ulcer (e.g. Esophageal, Gastric, and Peptic Ulcers); and was on a therapeutic diet (e.g., low salt, diabetic, low cholesterol).

12/15/22 [physician's order] "Nutrition - Oral diet: Heart Healthy (low fat, sodium select)..."

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F 657	Continued From page 34 12/20/22 at 4:26 PM [Nutrition Recommendation (dietitian) Note] "Continue Heart Healthy, 2 g (gram) Na+ (sodium) Diet with easy chew/IDD7 [International Dysphagia Diet Level 7 (Regular/easy to chew)] [and] diet texture; monitor PO (by mouth) intake and document on flow sheet the percentage of meals and volume of supplements consumed..." 12/20/22 [Nutritional Assessment] "RD (Registered Dietician) provided sitter with Heart Healthy 2gNA+ menu for ease of ordering, noting that some items may not be available due to the Easy to Chew/IDD7 diet texture ... Pt (patient) caregiver at bedside stated that ...family is bringing in pt lunch and dinner foods that are not in compliance w/heart healthy diet. Caregiver requesting to have pt diet transitioned to regular. Secure chat message sent to attending MD (medical doctor) w/this information." 12/27/22 at 9:56 AM [Nutrition Recommendation Note] "Continue Heart Healthy, 2g Na+ Diet with Easy to Chew/IDD7 diet texture. Please consider liberalization to regular diet as pt does not like menu options and is having family bring in lunch and dinner daily. Secure chat sent to MD [with] request." Review of the Nutritional status care plan with a start date of 12/19/22, showed no documented evidence that the facility staff revised this care plan to indicate that Resident #277's family was bringing in foods from outside. During a face-to-face interview on 01/09/23 at 10:00 AM, Employee #4 (Director of Nutrition Food) acknowledged the findings and made no	F 657		

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F 657	Continued From page 35 further comments. 2. Facility staff failed to update Resident #278's fall care plan after a fall. Resident #278 was admitted to the facility on 12/19/22 with multiple diagnoses that included: Sundowning, Spondylosis with Myelopathy, Hypertension and Hyperlipidemia. A Facility Reported Incident (FRI), DC00011445, received by the State Agency on 01/04/23 documented, "... Around 12:23 [AM] [on] January 3, 2023, received call from 6B that patient could not reach his call button. Nurse went to patient room, found him lying on his back, beside his bed talking to someone on using the hospital phone. When asked what happened patient said, "I tried to [sit] at the edge of the bed to use the urinal and I slid off the bed ... Patient said I did not hit my head and I don't feel any hurt. Resident was examined and did not sustain any injuries." Review of Resident #278's medical record revealed the following: An Admission Minimum Data Set (MDS) dated 12/26/22, where facility staff coded: cognitively intact; extensive assistance with one-person physical assist for bed mobility and transfers; extensive assistance with two-person physical assist for walking in room; extensive assistance with two-person physical assist, for surface-to-surface transfer; functional limitation/impairment in range of motion in both upper and lower extremities; uses a walker for mobility; and no falls since admission/entry of reentry to the facility.	F 657		

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F 657	Continued From page 36 01/03/23 at 8:22 AM [Nurse progress note] "Patient is alert x 3, around 0025 (12:25 AM) nurse received telephone call from 6B that patient could not reach his call button Nurse went to patient room and found patient lying on his back on the floor beside his bed. Patient said "I wanted to seat at the edge of the bed to urinate but I slide off the bed. Patient is on Aspirin (blood thinner), house supervisor and Rapid Respond called to the unit. Patient denied [hitting] his head and stated he just slide off the bed to the floor ...Patient remains stable, safety measures maintained ..." 01/03/23 at 1:54 AM [Physician progress note] "... I saw the patient after rapid response was called for a fall. The patient states that he was sitting at the side of the bed to urinate and was bending over. He states that he did not have his prescription socks on and began to slip forward. He states that he slipped forward but was able to lower himself to the floor with his arms. He states he was down for about 10 minutes before being helped back into the bed by nursing ...We will continue to monitor". 01/03/23 at 7:21 PM [Nurse's Note] "...safety... and fall precautions in placed (sp)" Review of the "Fall" care plan with a start date of 12/19/22, showed no documented evidence that facility staff revised it to include the actual fall on 01/03/22, or any new goals and approaches/interventions. During a face-to-face interview on 01/06/23 at 11:54 AM, Employee #5 (Charge Nurse) stated that the care plans are being reviewed.	F 657		

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F 657	Continued From page 37 DCMR - 3210.4	F 657		
F 695 SS=E	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 of nine (9) nasal cannulas (delivers oxygen via the nose), facility staff failed to maintain respiratory/oxygen care equipment in accordance with the professional standards of practice. The findings included: During an observation of the "Respiratory Equipment Cart" on 01/04/23 at 12:14 PM, nine (9) of nine (9) Vyaire (manufacturer) nasal cannula tubing with expiration dates of "2022-10-08" (October 8, 2022) were stored for resident use, approximately three (3) months after the expiration date. During a face-to-face interview conducted on 01/04/23 at 12:59 PM, Employee #12 (Respiratory Therapy Manager) stated, "There's no daily or weekly inventory check of the respiratory equipment cart. If supplies are needed, they [the nurses] call us and we bring the	F 695	**F695 – Respiratory/ Tracheostomy Care and Suctioning** 1. All expired nasal cannulas were removed from the cart by the respiratory care manager on January 5, 2023. a. There were no negative resident outcomes from this deficient practice. 2. All residents have the potential to be affected. • All expired supplies removed on 1/5/23. There were no negative resident outcomes. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: • Nasal cannulas were removed from the free-standing respiratory cart and are located and tracked in clean supply. • DON provided education to the nursing team on updated respiratory care supply location. • The free-standing respiratory supply cart has been removed from the unit on Jan 17, 2023. 4. Plan for Monitoring performance/sustainability: a. Respiratory care manager or designee will audit nasal cannula expiration dates in the clean supply room once a week until there are 4 consistent weeks of 100% compliance with unexpired nasal cannulas i. Audit report will be sent to the Administrator each week ii. Audit report will be shared in the monthly QAPI meeting until compliance is achieved for 4 consecutive weeks iii. Non- compliance will be tracked and addressed	

			immediately 5. Date corrective action will be complete: March 10, 2023	

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F 695	Continued From page 38 supplies." The employee was shown the expired nasal cannula tubing's and stated, "Oh wow! I will get rid of these and get new ones." Employee #12 further stated that the nasal cannulas come from central supply. During a face-to-face interview on 01/04/23 at 2:13 PM, Employee #13 (Supply Chain Manager) stated, "We are responsible for checking the expiration dates before putting them [nasal cannula tubing] for use on the units. We would be the root cause of something expired being on the units." DCMR 3215.4	F 695		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812	**F812 (1) – Food Tray Temp** 1.Immediate: • Defective bases were removed from service on Jan 6, 2023. • Nutrition Services Manger Contacted Base manufacturer to test our bases used for maintaining temperature in our patient trays on Jan 6, 2023. 2. All residents have the potential to be affected. • Defective bases were removed from service on Jan 6, 2023. • Nutrition Services Manger Contacted Base manufacturer on Jan 6, 2023 to test our bases used for maintaining temperature in resident trays • There were no negative outcomes for residents from this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: • Manager of Nutrition Services will provide education to the nutrition services team regarding correction of this deficient practice. • Nutrition services manager will implement daily test trays audits to ensure proper temperatures are maintained. • Nutrition services manager will implement monitoring of bases to ensure defective bases are not being used in service rotation.	

			• Nutrition services manager or designee will lead a weekly huddle to review test tray audit findings with nutrition services staff. • 4. Plan for Monitoring performance/sustainability: • Daily Test Tray Audit will be completed by nutrition services staff • Test tray audit compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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F 812	Continued From page 39 by: Based on observations and staff interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by: foods such as grilled chicken and beans that tested below 135 degrees Fahrenheit (F); inconsistent dish machine final rinse temperatures that were below 180 degrees Fahrenheit (F); and a crawling pest that was observed on the kitchen floor. The findings included: • Lunch food temperatures were inadequate and failed to test above 135 degrees Fahrenheit (F) or more during a food tray test on January 4, 2023, at approximately 1:00 PM, on two (2) of three (3) observations. Grilled chicken breast tested at 126 degrees Fahrenheit, and black beans tested at 127 degrees Fahrenheit. • Final rinse dish machine temperatures failed to reach 180 degrees Fahrenheit during observations on January 4, 2023. Dishes and utensils were disinfected with the disinfectant solution from the 3-compartment sink. Final rinse temperatures were normal on January 5, 2023, at approximately 2:30 PM • A crawling insect was observed on the kitchen floor near the grill during observations on January 5, 2023, at approximately 2:30 PM. Employee #4 acknowledged the findings on January 6, 2023, at approximately 10:00 AM.	F 812	**F 812 (2) – Dish machine temps** 1.Immediate: Dish machine unit was cleaned on Jan 5, 2023. 2.All residents had the potential to be impacted by this deficient practice. o There were no negative resident outcomes. Systemic changes that will be made to ensure deficient practice does not reoccur: • Manager of Nutrition Services will provide education to the nutrition services team regarding correction of this deficient practice. • Nutrition Services Manager or designee will implement daily Monitoring tool for Dish machine Temperatures tracking • Nutrition Services Manager will implement additional days of scheduled preventive maintenance for Dish-machine. 4. Plan for Monitoring performance/sustainability: • Nutrition Services Manager will receive a weekly report from Ecolab to ensure dish machine is functioning properly • Daily audit of Temperature will be completed by nutrition services staff • Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023 **F812 (3)– Pest** 1.Immediate: Nutrition Services team member removed insect and discarded all food within suspected area on Jan 5, 2023. • All residents had the potential to be impacted by this deficient practice. • Removed insect and discarded all food within suspected area Jan 5, 2023. • There were no negative resident outcomes from this deficient practice.	

F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	Systemic changes that will be made to ensure deficient practice does not reoccur: • Manager of Nutrition Services will provide education to the nutrition services team regarding correction of this deficient practice • Nutrition Services manager will Develop/implement tool for daily auditing of the area affected • Regional pest control will be on-site every Friday to assess, monitor, and control the area. 4. Plan for Monitoring performance/sustainability: • Manager of Nutrition Services will receive a weekly report from Regional Pest Control on the targeted area. • Nutrition services manager or designee will complete a Daily audit of targeted areas • Compliance will be reported monthly at each QAPI meeting until >90% compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023 **F880 Infection Prevention and Control** 1. Employee #9 and #14 were made aware of the deficient IP practices and the behavior was corrected. a. There was no negative impact on residents from the deficient practice. 2. All residents have the potential to be affected/ corrective action taken: a. There are signs posted throughout the facility to address required PPE use, and safe infection prevention practices. b. There was no negative impact on residents from the deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. RCA regarding infection control deficiencies was completed on 2/21/2023 b. Nutrition Services Manager to provide education to the nutrition services team regarding proper PPE use (face mask) and hand hygiene practices when entering resident rooms c. Director of Nursing Excellence and	

			Education to provide education to the wound care nursing team regarding technique for carrying soiled linen when providing wound care d. Signage posted on all resident doors to remind staff/visitors to practice hand hygiene before entering the room. 4. Plan for Monitoring performance/sustainability: a. 10 monthly hand hygiene audits will be completed by the QA Coordinator or designee b. 10 monthly PPE use will be completed by the QA Coordinator or designee c. 5 monthly audits of proper linen carrying will be completed by Director Excellence in Nursing Practice or designee d. Results of the audits will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months. e. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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F 880	Continued From page 40 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 41 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, for one (1) of 16 sampled residents, the facility's staff failed to maintain infection control policies and procedures as evidenced by: inappropriately transporting soiled linen; staff not performing hand hygiene and wearing a facemask inappropriately during meal tray distribution. Resident #1. The findings included:	F 880		

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F 880	Continued From page 42	F 880		

Review of the facility's policy titled "Wound Care Policy" with an effective date of 06/23/20 instructed staff to "...maintain standard precautions and isolation precautions as indicated. After completion of the procedure, clean, store and/ or dispose of equipment and supplies in the appropriate manner as identified per facility infection control policy..."

Review of the policy titled "Hand Hygiene Policy" with an effective date of 06/15/20 instructs staff to do the following " ...Hand hygiene with either alcohol-based hand sanitizer and or soap and water is required ...Before handling food ...when carrying supplies, dietary trays or transporting a patient into or out of a room, hand hygiene is required as soon as hands are free..."

Review of the CDC (Center for Disease Control) guidelines for "best practices for linen and laundry handling instructed, " ...Never carry soiled linen against the body. Always place it in the designated container."

https://www.cdc.gov/hai/prevent/resource

1. Employee #9 failed to appropriately transport soiled linens after providing wound care for Resident #1 who is on contact precautions/isolation.

Resident #1 was admitted to the facility on 11/04/22 with diagnoses including: Pressure Ulcer Sacral Region Stage 4, Non-Healing Right Heal Wound, Multiple Wounds, and Heart Failure.

During an observation on 01/06/23 starting at 10:48 AM, Employee #9 (Registered Nurse) was

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F 880	Continued From page 43	F 880		

observed performing wound care dressing change to Resident #1's Stage 4, sacral, pressure ulcer. After changing the resident's wound dressings, Employee #9 picked up a soiled blanket, placed it under her arm, which moved the protective gown, causing direct contact of the soiled blanket with the employee's uniform.

It should be noted that Resident #1 had a sign on his door stating that he was on "Contact Isolation Precautions" requiring staff to wear personal protective equipment (gown, gloves, and mask) when entering the room to provide care.

A review of the medical record revealed the following:

11/04/22 at 12:34 PM [Physician's Order] "...Contact isolation ..."

01/06/23 at 10:09 AM [Physician's Order] "...change dressing...dressing type: cleanse the wound with Vashe (Wound cleanser) with VAC (vacuum-assisted closure) dressing change Site: Sacrum ...2 times weekly ..."

During a face-to-face interview conducted at the time of the observation, Employee #9 (Registered Nurse) stated, "I wasn't thinking but I know better."

2. Facility staff failed to perform hand hygiene and was observed not wearing their facemask appropriately.

During an observation on 01/04/23 at approximately 12:00 PM, Employee #14 (Dietary

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F 880	Continued From page 44 Aide) was observed on the unit pushing a meal cart down the hallway and stopping at each resident's room. The employee was noted to be wearing a face mask below the nose, and only partially covering their mouth. Employee #14 was also seen not performing hand hygiene in between coming out of one resident's room, and then touching and delivering another resident's meal tray. At the time of the observation, Employee #14 was asked why his facemask was not covering his nose and mouth. The employee refused to answer. This observation was brought to the attention of Employee #2 (Director of Nursing) on 01/04/23 at 12:03 PM. Employee #2 acknowledged the findings and made no comment.	F 880		
F 908 SS=D	DCMR 3217.6 Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by dish machine final rinse temperatures that were below 180 degress Fahrenheit on January 4, 2023, at approximately 2:30 PM. The findings included:	F 908	**F 908 – Dish machine temps** 1.Immediate: The dish machine unit was cleaned on Jan 5, 2023. 2.All residents had the potential to be impacted by this deficient practice. • There were no negative resident outcomes from this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: • Manager of Nutrition Services will provide education to the nutrition services team regarding correction of this deficient practice	

			• Nutrition Services Manager or designee will implement a daily Monitoring tool for Dish machine Temperature tracking • Nutrition Services Manager will implement additional days of scheduled preventive maintenance for Dish-machine. 4. Plan for Monitoring performance/sustainability: • Nutrition Services Manger will receive a weekly report out from Ecolab to ensure dish machine is functioning properly • Daily audit of Temperature will be completed by nutrition services staff • Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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F 908	Continued From page 45 During observation in dietary services on January 4, 2023, at approximately 2:30 PM, final rinse temperatures from the dish machine were about 154 degress Fahrenheit and did not reach a minimum of 180 degress Fahrenheit (F) as required. Dishes and utensils were disinfected from the three-compartment sink disinfectant solution. Final rinse temperatures were at or above 180°F on January 5, 2023, at approximately 2:30 PM Employee #4 acknowledged the findings on January 4, 2023, at approximately 3:00 PM.	F 908		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to maintain an effective pest control program as evidenced by a crawling pest observed on the floor, around the flat grill, in dietary services. The findings included: A crawling pest was seen on the kitchen floor, by the flat grill, on January 5, 2023, at approximately 2:30 PM. The vermin was removed and discarded by staff. Employee #4 (Director of Nutrition Food) acknowledged the findings on January 6, 2023, at approximately 10:00	F 925	**F925 – Pest** 1. Immediate: A Nutrition Services team member removed insect and discarded all food within the suspected area on Jan 5, 2023. 2. All residents had the potential to be impacted by this deficient practice. • Removed insect and discarded all food within the suspected area on Jan 5, 2023. • There were no negative resident outcomes from this deficient practice. Systemic changes that will be made to ensure deficient practice does not reoccur: • Manager of Nutrition Services will provide education to the nutrition services team regarding correction of this deficient practice • Nutrition Services manager will Develop/implement tool for daily auditing of area affected • Regional pest control will be on-site every Friday to assess, monitor and control area. 4. Plan for Monitoring performance/sustainability: • Manger of Nutrition Services will receive a weekly report from Regional Pest Control on the targeted area.	

			• Nutrition services manager or designee will complete a Daily audit of targeted areas • Compliance will be reported monthly at each QAPI meeting until >90% compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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