STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	C 09/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint/facility reported incidents survey was conducted at Capitol City Rehab and Healthcare Center from September 9, 2022 to September 20, 2022. Survey activities consisted of a review of nine (9) sampled residents. The facility's census during the survey was 330. Complaints DC00010871 and DC00010974 and facility reported incidents DC00010955, DC00010956, DC00010957, DC00010958, DC00010973, DC00010975 were investigated during this survey. Deficiencies were cited related to the investigation of DC00010871, DC00010956, DC00010958, DC00010974, DC00010973, DC00010975, . 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 deficiencies are based on observation, record review, and resident and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	11/7/22

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 QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to	F 551	F551 1.Resident #3 currently resides in the facility. No ill effects noted as a result of the deficiency. The resident's face sheet was updated to reflect the correct resident representative.	11/21/2022

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F 551	Continued From page 3 exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law	F 551	2. The Unit Managers or designee will review the current residents in the facility to ensure the correct identification of the resident's representative is noted on the resident face sheets. Modifications will be made immediately when warranted. 3. The Administrator or designee will in-service the facility admissions department staff, social work staff, and unit secretaries to ensure that a competent resident representative is identified and noted on the face sheet. 4. The Administrator or designee will audit 25% of the resident face sheets to ensure they accurately reflect the resident's representative weekly x 4, then monthly x 3 months. Results of the audits will be submitted to the Quality Assurance and Performance Committee.	

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F 551	Continued From page 4 or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on observations, records reviews, and interviews with Resident #3, the resident's family, and staff, the facility failed to ensure that Resident #3 had a competent representative for one (1) of nine (9) sampled residents. The findings included: Resident #3 was admitted to the facility on 07/12/22 with multiple diagnoses, including vascular dementia without behavior disturbance, cerebral infarction, dependence on renal dialysis and acidosis. Review of a Family Compliant (DC00010974) dated 09/06/22 at 11:34 AM, documented, "My mom is there for dialysis, and she is a fall risk due to having a stroke ...my mom has a blackeye and stiches on her [left] eyebrow ... [evening supervisor's name] told me my mom is responsible for herself (which is not true). My mother cannot make decisions for herself, and the facility knows this because they call and ask for signatures all the time. All of sudden, when she hurt herself so bad to the point of needing stitches, they now say that she is responsible for herself ..."	F 551		

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F 551	Continued From page 5 On 09/09/22 at 11:35 AM, Resident #3 was observed sitting in a chair in her room. As the surveyor attempted to ask questions to assess Resident #3 orientation (cognition) status, she repeatedly said "food" very loudly. On 09/12/22 at 9:50 AM, Resident #3 was observed lying in bed. The resident was oriented to name only. Review of the resident's medical record showed the following: 07/19/22 [Admission Minimum Data Set (MDS)] documented Resident #3 had a Brief Interview for Mental Status (BIMs) summary score of "8, which indicated that the resident had a moderately impaired cognition status. 07/21/22 [Nursing Brief Interview for Mental Status] documented that the resident had a summary score of "3", which indicated that the resident had a severely impaired cognition status. 09/02/22 [Physician Order] transfer resident to ER (emergency room) for CT (Computed Tomography) scan of head. 09/02/22 at 7:04 PM [Situational, Background, Assessment, Recommendation Tool]documented, "Resident fell ...and cofuse[confusion] made the problem worse ... sustained a laceration to left [side of] forehead ...transferred to [local hospital] for further evaluation ..." 09/02/22 at 11:51 PM [Nursing Note] documented, "Resident returned from [local hospital's name] due to fall/laceration ... no fractures or dislocation ...left periorbital soft tissue	F 551		

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F 551	Continued From page 6 swelling and probable small hematoma ...on assessment left eye is noted with bruises and swelling. Left eyelid is noted with stiches ...Resident is self RP (responsible party). A review of Resident #3's face sheet revealed that the resident was her own responsible party." During a telephone interview on 09/12/22 starting 9:14 AM, the complaint stated that when her sister told her that when she visited their mom, she inquired as to why they had not been informed about their mother's fall with injury (left black eye and laceration to brow). The supervisor (employee name in the complaint) explained to her sister that they weren't called because the record showed that her mom was listed as her own responsible party. The complaint then said that the facility had contacted her in the past for permission to perform dialysis since her mom is unable to make decisions, so she couldn't understand why they hadn't informed her of her mom's fall with injuries. During a face-to-face interview on 09/15/22 at approximately 2:30 PM, Employee #2 (DON) reviewed the previously mentioned face sheet and stated that the resident's identification as her own responsible party was an "error". Employee #2 then said, "She [Resident #3] should not have been her own responsible party because she can't make safe decisions. We will fix it."	F 551		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		

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F 583	Continued From page 7 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's staff failed to ensure a resident's social security number was not provided to an unrelated person for one (1) of nine (9) sampled residents (Resident #9). The findings included:	F 583	F583 1. Resident #9 was discharged from the facility on 1/30/21. No ill effects noted as a result of the deficiency. Upon being made aware on March 23, 2022 of the issue related to the wrong Medical Records Invoice being made available, the link to Resident #9's Medical Records invoice was immediately deleted. Employee #16 received a disciplinary action and re-education on 3/25/22 for the unintentional breach of PHI. The facility removed all resident identifying information from the Medical Records Invoice form and further modified its practices related to providing medical records. 2. The Medical Records Director or designee will review the past 30 days' requests for medical records to ensure that no PHI was inadvertently breached. 3. The Administrator or designee will in-service the medical records personnel on the requirements to ensure PHI is kept confidential. 4. The Medical Records Director or designee will audit all medical records requests to ensure that resident PHI is not breached weekly x 4, then monthly x 3 months. Results of the audits will be submitted to the Quality Assurance and Performance Committee.	11/21/22

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F 583	Continued From page 8 Review of Compliant (DC00010958) dated 07/09/22 at 4:58 PM, documented, " ...On March 21st, 2022 [Employee #16's name] had forwarded [emailed]another patient [Resident #9] personal information...SSN# (social security number) and other personal information ..." Review of administrative documents showed Employee 16's [medical records coordinator] employee discipline report dated 03/25/22 for "a resident's [Resident #9] identifying information ...SSA# (social security number) was provided to a non-requesting/approved recipient ..." During a face-to-face interview on 09/15/22 at 11:12 AM, Employee #1 (Administrator) stated that an employee sent Resident #9's social security number by mistake to the complainant. The employee then said that he notified Resident #9's family of the error because the resdient was transferred to the hospital and did not return. Furthermore, Employee #1 stated that they were in talks with the Department of Civil Rights about this matter.	F 583		
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 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.	F 584	F584 1. Resident #7 currently resides in the facility. No ill effects noted as a result of the deficiency. Resident #7's room and bathroom are cleaned daily and the cleaning is documented per facility's protocol. 2. The Environmental Service Director or designee will audit the resident rooms and bathrooms to ensure that the resident rooms and bathrooms are cleaned.	11/21/22

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F 584	Continued From page 9 (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 observation, record review and interviews, the facility's staff failed to have documented evidence Resident #7's room and bathroom were cleaned on 04/17/22 and 06/23/22 for one (1) of nine (9) sampled residents. The findings included:	F 584	3. The Environmental Service Director or designee will in-service the environment service personnel that the residents' room and bathrooms must be cleaned daily and documentary evidence of the cleaning must be present. 4. The Environmental Service Director or designee will audit 20% of the resident rooms and bathrooms to ensure they are cleaned and that documentary evidence exists weekly x 4, then monthly x 3 months. Results of the audits will be submitted to the Quality Assurance and Performance Committee.	

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F 584	Continued From page 10 Review of Compliant (DC00010958) dated 07/09/22 at 4:58 PM, documented, " ...On April 17th, 2022 (Easter) ... [Resident #7's] room was in a disarray, her bed had not been made and there was feces on the blanket. [Resident #7's name] expressed that they do this all [the] time, they never clean her room ... On June 23rd, 2022 [Resident #7's name] bathroom is unsanitary ..." Resident #7 was admitted to the facility on 05/25/22 with multiple diagnoses including unspecified glaucoma, difficulty walking, and muscle weakness. During an observation on 09/14/22 at 8:35 AM, Resident #7's room had trash on the floor near the head and foot of the resident's bed. At the time of the observation, Resident #7 said that she was legally blind, and she could not see things when they fell on the floor. Also, the resident stated that the staff was not always helpful in cleaning her room. A second observation at approximately 3:00 PM that same day found the resident room clean and without trash. A review of environmental service cleaning documents lacked documented evidence Resident #7's room or bathroom had been cleaned on 04/17/22 or 06/23/22. During a telephone interview on 09/15/22 at approximately 9:30 AM, the complainant stated that when she returned from an appointment with Resident #7 on 04/17/22, the resident's room hadn't been cleaned and feces was on the resident's blanket. In addition, the complaint said that when she visited the resident on 06/23/22, the resident's bathroom was dirty. There was feces on the toilet seat, and the water was not on	F 584		

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F 584	Continued From page 11 for her to wash her hands. The complainant also reported that Resident#7 was legally blind, and that staff did not assist her with keeping her room neat. During a face-to-face interview on 09/15/22 at approximately 1:00 PM, Employee #14 (Environmental Services Director) stated that all residents' rooms and bathrooms are cleaned daily, but he did not have any documented evidence of Resident #7's room and bathroom being cleaned on 04/17/22 and 06/23/22.	F 584		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility's staff failed to ensure two (2) of nine (9) sampled residents were free from involuntary seclusion (Residents' #4 and #5). The findings included:	F 603	F603 1. Resident #4 currently resides in the facility. Resident #5 was discharged on 8/31/22. No ill effects noted as a result of the deficiency. Employee #9 was educated on 8/26/22 that every resident has a right to be free from all forms of abuse, including involuntary seclusion, and received disciplinary action on 8/31/22. 2. The facility Unit Managers initiated a facility wide review of current residents on 8/29/22 to determine if there was any involuntary seclusion of a resident. 3. The Nurse Educator initiated staff education on 8/26/22 and ongoing on the facility's abuse policy; specifically, the residents' right to be free from all forms of abuse including involuntary seclusion.	11/21/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 603	Continued From page 12 Review of a Facility Reported Incident (DC00010958) dated 08/31/22 at 2:46 AM, documented, "On August 26, 2022, at approximately 12:25 PM it was reported that the residents [Residents' #4 and #5] in Room 341 were allegedly involuntary secluded during the previous night [08/30/22] by an employee. The door of the residents' room was tied shut with a plastic bag ...A full assessment was completed by the nurse. No physical injury was observed ...During the investigation [Certified Nursing Assistant's name] ...stated that [Resident #4's name] continued to come out her room (341) that night without clothing ... she was successful at redirecting the resident [Resident #4] ...but when [Certified Nursing Assistant's name] needed to attend to another resident [Certified Nursing Assistant's name] closed the door [room 341] and tied a plastic bag to the door knob and handrail to keep [Resident #4's name] from exiting her room without her clothing ..." 1.Resident #4 was admitted to the facility on 05/25/22 with multiple diagnoses including unspecified psychosis, altered mental status, generalized muscle weakness, and unsteadiness on feet. On 09/12/22, 09/14/22 and 09/15/22 starting at approximately 11:50 AM to 2:00 PM, Resident #4 was observed wandering in the hallway walking very fast from one end to the other. On 09/12/22 the resident was easily re-directed by staff to her room and assisted her with putting her shoes on. Although Resident #4 was easily redirected, the resident was not able to be interviewed because she was only oriented times one (name). Review of the resident's medical record revealed	F 603	4. The Director of Nursing or designee will audit 20% of the facility census to determine if any resident was involuntarily secluded in their room by a staff member weekly x 4, then monthly x 3 months. Results of the audits will be submitted to the Quality Assurance and Performance Committee.	

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	095022	A. BUILDING _____ B. WING _____	C 09/20/2022

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F 603	Continued From page 13 the following: 06/01/22 [Admission Minimum Data Set (MDS)] revealed Resident #4 had a Brief Interview for Mental Status summary score of "2", which indicated the resident's cognitive function was severely impaired. Further, Resident #4 was coded as requiring extensive assistance with the physical assistance from one staff member for dressing. The resident was also coded for requiring limited physical assistance from one staff member for locomotion in the corridor. In addition, the resident was coded for using a wander/elopement alarm every day. 08/26/22 at 12:57 PM [Situation, Background, Assessment and Request] documented, "Situation - Writer was informed at about 12:25 PM that the resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ...Assessment - involuntary seclusion ..." 08/26/22 at 9:41 PM [Unit Manager Note] documented, "writer was informed at about 12:25 PM that the resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ... no distress, pain or discomfort noted ...staff in-service initiated ..." Review of Resident #4's care plan revealed the following: Focus area "[Resident #4's name] is at risk for exit seeking (elopement risk). Disoriented to place, impaired safety awareness. Resident wanders aimlessly ... The care plan outlined multiple interventions including monitor closely [Resident #4] where abouts, redirections as needed ..."[this care plan had a revision date of 07/16/22].	F 603		

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F 603	Continued From page 14 Focus area "[Resident # 4's name] was involved in a staff involuntary seclusion. The care outlined a few interventions including staff education on the risk of secluding resident. (The care plan was initiated on 08/26/22). 2.Resident #5 was admitted to the facility on 06/22/22 with multiple diagnoses including unspecified dementia without behavioral disturbance, generalized muscle weakness, and altered mental status. Review of the resident's medical record showed the following: 08/04/22 [Quarterly Minimum Data Set (MDS)] revealed Resident #5 had a Brief Interview for Mental Status summary score of "4", which indicated the resident's cognitive function was severely impaired. Further, Resident #5 was coded as requiring supervision with the physical assistance from one staff member for walking in room. The resident was also coded for requiring extensive physical assistance from one staff member for toilet use. In addition, the resident was not using physical restraints or alarms. 08/26/22 at 1:32 PM [Unit Manager Note] documented, "writer was informed at about 12:25 PM that the resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ... no distress, pain or discomfort noted ...staff in-service initiated ..." 08/26/22 at 4:53 PM [Situation, Background, Assessment and Request] documented, "Situation - resident's doorknob was found tied with a plastic trash bag to the hallway grab rail. When asked, resident said nothing happened and	F 603		

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F 603	Continued From page 15 I" ...Assessment - involuntary seclusion ..." Review of Resident #5's care plan revealed the following: Focus area "[Resident # 5's name] was involved in a staff involuntary seclusion. The care outlined a few interventions including staff education on the risk of secluding resident. (The care plan was initiated on 08/26/22). Resident #5 was not available for interview during this survey period due her admission to the hospital on 08/31/22. Review of the facility's investigative notes revealed Employee #9's (Certified Nursing Assistant) written statement signed on 08/26/22. The employee documented, "I was doing my last rounds and [Resident #4's name] was coming out naked so I closed her door and tied a plastic bag on the doorknob to prevent her from coming out of the room and walking around naked. After I was done with my rounds I forgot to untied [sp] the plastic bags from the doorknob." Continued review of the facility's investigative notes showed the Director of Nursing (Employee #2) interview notes with Employee #9 (Certified Nursing Assistant) conducted on 08/26/22. Employee #9 stated, "When I had to do rounds on my other residents, I tied a plastic bag to the door so she [Resident #4] would stay inside and not expose herself ...I had to protect her ... I didn't want her to be exposed to everyone. I even thought about taking her with me when I was rounding, so I wouldn't have to tie the door ... I thought I did the right thing to protect her. (Employee was educated that her intent was fine,	F 603		

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F 603	Continued From page 16 but her method was inappropriate and could be considered abuse. Explained that the residents [Residents' #4 and #5] freedom was restricted. Also discussed resident rights) ..." During a face-to-face interview, Employee #10 (Certified Nursing Assistant) was interviewed face-to-face on 09/12/22 at 12:15 PM, she stated that she observed four white plastic trash bags tied to Residents' #4 and #5 doorknob and grabrail outside the residents' rooms on 08/26/22 at approximately 9:00 AM while passing breakfast trays. Employee #10 also reported that when she removed the trash bags and opened the door, Resident #4 walked toward her, but she stopped her because she noticed urine and water near it. Additionally, the employee said "The bathroom (shared with another room) door was locked so the residents could not get out the room. They were locked in this room." When asked about Resident #5, the employee replied that the resident was awake and lying in bed. In response to the question, did she notice the trash bags tied to the door at 7:00 AM when she began her shift? The employee stated, "No, I didn't have that team that day." During a face-to-face interview on 09/12/22 at 12:18 PM, Employee #11 (Unit Manager) stated that Employee #9 (Certified Nursing Assistant) admitted to the Director of Nursing (Employee #2) that she tied the door of room 341 [Residents' #4 and #5] shut with trash bags. When asked why the incident with the door was discovered two (2) hours after the shift started? The employee said that because of the incident, she instructed her staff to start giving and receiving reports during walking rounds (off going and on coming staff will go from room to room) at the change of all shifts.	F 603		

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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 record review and interviews, for three (3) of nine (9) sampled residents, the facility staff failed to conduct thorough investigations by not having documented evidence of all staff interviews or written statements for the following allegations of abuse: two (2) residents who were secluded to their room involuntarily by Employee #9; and one (1) resident who engaged in a verbal and physical altercation with Employee #17 (Residents' #4, #5 and #8). The findings included: Review of the facility's policy entitled, "Abuse, Neglect, and Exploitation" with a copyright date 2022, the policy instructed staff to, "Identify and interviewing all involved persons ...and other who	F 610	F610 1. Residents #4 and #8 currently reside in the facility. Resident #5 was discharged on 8/31/22. No ill effects noted as a result of the deficiency. The Director of Nursing will obtain the witness statements from the remaining staff members that were scheduled on the 8/25/22 and 9/7/22 night shifts. 2. The Director of Nursing or designee will review the past 30 days of facility reported incidents related to allegations of abuse to ensure a thorough investigation was completed by obtaining witness statements or interviews. 3. The Director of Nursing or designee will inservice the facility staff that a thorough investigation must be completed by obtaining witness statements or interviews from involved persons, including the alleged victim and perpetrator as applicable, witnesses and others who might have knowledge of the allegation.	11/21/22

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F 610	Continued From page 18 might have knowledge of the allegation ..." 1a.Resident #4 was admitted to the facility on 05/25/22 with multiple diagnoses including unspecified psychosis, altered mental status, generalized muscle weakness, and unsteadiness on feet. On 09/12/22, 09/14/22 and 09/15/22 starting at approximately 11:50 AM to 2:00 PM, Resident #4 was observed wandering in the hallway walking very fast from one end to the other. On 09/12/22 the resident was easily re-directed by staff to her room and assisted her with putting her shoes on. Although Resident #4 was easily redirected, the resident was not able to be interviewed because she was only oriented to her name. Review of the resident's medical record revealed the following: 08/26/22 at 12:57 PM [Situation, Background, Assessment and Request] documented, "Situation - Writer was informed at about 12:25 PM that the resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ...Assessment - involuntary seclusion ..." 08/26/22 at 9:41 PM [Unit Manager Note] documented, "writer was informed at about 12:25 PM that the resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ... no distress, pain or discomfort noted ...staff in-service initiated ..." 1b.Resident #5 was admitted to the facility on 06/22/22 with multiple diagnoses including unspecified dementia without behavioral disturbance, generalized muscle weakness, and altered mental status.	F 610	4. The Director of Nursing and designee will audit all allegations of abuse to ensure a thorough investigation was completed by obtaining witness statements or interviews from involved persons, including the alleged victim and perpetrator, witnesses and others who might have knowledge of the allegation weekly x 4, then monthly x 3 months. Results of the audit will be submitted to the Quality Assurance and Performance Committee.	

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F 610	Continued From page 19 Review of the resident's medical record showed the following: 08/26/22 at 1:32 PM [Unit Manager Note] documented, "writer was informed at about 12:25 PM that the resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ... no distress, pain or discomfort noted ...staff in-service initiated ..." 08/26/22 at 4:53 PM [Situation, Background, Assessment and Request] documented, "Situation - resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ...Assessment - involuntary seclusion ..." Review of the facility's investigative notes revealed Employee #9's (Certified Nursing Assistant) written statement signed on 08/26/22. The employee documented, "I was doing my last rounds and [Resident #4's name] was coming out naked so I closed her door and tied a plastic bag on the doorknob to prevent her from coming out of the room and walking around naked. After I was done with my rounds I forgot to untied [sp] the plastic bags from the doorknob." Review of the staff assignment sheet dated 08/25/22 revealed seven (7) employees worked the night shift (11:00 PM - 7:00 AM) that day. However, continued review of the facility's investigative notes lacked documented evidence that three (3) of the seven (7) employees were interviewed or provided a written statement regarding the allegation of involuntary seclusion of Residents' #4 and #5. During a face-to-face interview on 09/15/22 at	F 610		

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F 610	Continued From page 20 approximately 2:00 PM, Employee #2 (DON) stated that she was working on ensuring that all employee who worked during the time of an incident are interviewed and provide a written statement. Cross reference 483.12 Freedom from Abuse, Neglect, and Exploitation, F603 2.Resident #8 was admitted to the facility on 09/12/21 with multiple diagnoses including major depressive disorder, anxiety disorder, mood affective disorder, and schizophrenia. Review of the Facility Reported Incident (DC00010973) dated 09/08/22 at 10:45 AM, documented, "Resident reported around 12:30 PM today that an employee threatened to shoot him and also hit him with a folding chair in his side. Resident stated that the incident occurred early this morning outside the facility ..." Review of the resident's medical record showed the following: 08/23/22 [Admission Minimum Data Set (MDS)] revealed Resident #8 had a Brief Interview for Mental Status summary score of "15", which indicated the resident's cognitive function was intact. Further review of the MDS showed the resident was not coded for physical or verbal behavioral symptoms toward others such as hitting, threating or cursing. Additionally, Resident #8 was not coded for receiving psychological therapy. 09/08/22 at 2:49 PM [Assistant Director of	F 610		

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F 610	Continued From page 21 Nursing Note] documented, "Resident reported around 12:30 PM today that an employee threatened to shoot him and also hit him with a folding chair ...the incident occurred early this morning outside the facility ...Resident was examined by [nurse practitioner's name] with the unit manager present and there were no visible signs of injury, nor did the resident complain of pain ..." 09/08/22 at 4:46 PM [Situation, Background, Assessment, and Request Form] documented, "Situation- resident reported around 12:30 PM today that an employee threatened to shoot him and also hit him with a folding chair in his side ... Assessment - alleged staff to resident interaction ..." Review of Resident #8's care plan dated 09/08/22 revealed the following: Focus area [Resident's name] reported a verbal threat from a staff r/t (related to) verbal and mental abuse by staff ... Interventions included: continue staff education, employee suspended, and psych(ological) consult ... Review of the staff assignment sheet dated 09/07/22 revealed seven (7) employees worked the night shift (11:00 PM - 7:00 AM) that day. However, the facility's investigative notes related to the previously mentioned incident lacked documented evidence three (3) of the seven (7) employees were interviewed or provided a written statement about the alleged verbal and physical altercation between Resident #8 and Employee #17. During a face-to-face interview on 09/12/22 at 4:00 Pm, Resident #8 explained that he visited	F 610		

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F 610	Continued From page 22 another unit (1 South) to ask another resident for a cigarette, but Employee #17 (Certified Nursing Assistant) told him not to knock on the resident's door. Employee #17 and him began arguing and cursing at each other when he attempted to knock on the resident's door. The employee then told him to step outside, so he did. Once outside, Employee #17 hit him with a folding chair and threatened to shoot him. When asked if anyone witnessed the verbal altercation? The resident stated, "Everyone who worked on 1 South witnessed and heard our argument." When asked if anyone witnessed the physical altercation? Resident #8 said, "No, because it happened at the top of the hill (outside the property)." During a face-to-face interview on 09/15/22 at approximately 2:00 PM, Employee #2 (DON) stated that she was working on ensuring that all employee who worked during the time of an incident are interviewed and provide a written statement.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's staff failed to provide restorative nursing	F 684	F684 1.Residents #2 and 3 currently reside in the center. No ill effects noted as a result of the deficiency. Both residents were re-evaluated for the restorative nursing program. Resident #2 restarted physical therapy for general weakness on 10/13/22 and occupational therapy for therapeutic activities on 10/11/22. Resident #3 began occupational therapy for therapeutic exercises on 9/8/22 and speech therapy for skilled dysphagia and cognitive-communication intervention on 9/29/22. Employee #5 will receive education on the necessity of referring residents discharging from therapy to the restorative program as appropriate.	11/21/22

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F 684	Continued From page 23 services as ordered by a physician for two (2) of nine (9) sampled residents. (Residents' #2 and #3). The findings included: 1.Residents #2 was admitted to the facility on 01/05/22 with multiple diagnoses, including muscular weakness, tremors, lack of coordination, and altered mental status. A review of Resident #2's Quarterly Minimum Data Set (MDS) dated 07/26/22, showed the resident had a Brief Interview of Mental Status summary score of "14" which indicated the resident's cognitive functioning was intact. Continued review of the MDS revealed the resident required extensive physical assistance from two staff members for bed mobility. The resident was also coded as totally dependent on the physical assistance of two staff members for transferring between surfaces such as bed, chair, and wheelchair. Review of Resident #2's medical record revealed the following: 04/19/22 [physician order] - Restorative eval[uation] and treat as needed. 06/26/22 [fall risk evaluation] documented that the resident had a fall risk score of "6" which indicated Resident #2 had a "moderate risk" of falling. 08/29/22 [occupation therapy discharge note] documented -" ... discharge recommendation ... restorative nursing program ... to facilitate patient	F 684	2. The Director of Nursing or designee will review the past 30 days of therapy discharges to ensure that referrals to restorative nursing services are made as necessary as per the physician's order. 3. The Director of Nursing or designee will inservice the rehabilitation department on the need to make timely communication of the resident recommendations for restorative services. 4. The Director of Nursing or designee will audit the therapy discharges to ensure that referrals to restorative nursing services are made as necessary as per the physician's order weekly x 4, then monthly x 3 months. Results of the audits will be submitted to the Quality Assurance and Performance Committee.	

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F 684	Continued From page 24 maintaining current level of performance ... [to] prevent decline, ... [provide] range of motion (active) and bed mobility." 09/01/22 at 7:34 PM [nursing note] documented - "At about 4:20 PM report received from staff stating that resident was observed on the floor faced down lying on his stomach beside his bed ...Noted bleeding and swelling on the forehead. [Nurse practitioner's name] made aware and order given to transfer resident to nearest ER (emergency room) for fall with head injury ..." 2. Resident #3 was admitted to the facility on 07/12/22 with multiple diagnoses, including muscle weakness, lack of coordination, osteoarthritis, and transient ischemic attack. A review of Resident #3's Quarterly Minimum Data Set (MDS) dated 07/19/22 revealed that the resident had a Brief Interview for Mental Status summary score of "8" which indicated the resident's cognitive functioning was moderately impaired. Continued review of the MDS revealed the resident required extensive physical assistance from two staff members for bed mobility and transferring between surfaces such as bed, chair, and wheelchair. Review of the resident's medical record showed the following: 07/12/22 [physician order] - Restorative eval[uation] and treat as needed. 07/12/22 [fall risk assessment] documented that the resident had a score "22" which indicated Resident #3 was at a "high risk" for falling."	F 684		

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	095022	A. BUILDING _____ B. WING _____	C 09/20/2022

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F 684	Continued From page 25 08/19/22 [occupation therapy discharge note] documented -" ... discharge recommendation ... restorative nursing program ... to facilitate patient maintaining current level of performance ... [to] prevent decline, ... [provide] range of motion (active) and bed mobility." 09/02/22 at 6:31 PM [nursing note] documented - "At about 8:30 AM, resident noted on the floor crawling. On assessment resident noted laceration on left brow, pressure applied ... Resident transferred back to bed with 4 staff assistance. MD (medical doctor) called and ordered ER (emergency room) transfer ..." 09/02/22 [physician order] - transfer resident to ER (emergency room) for CT (computed tomography) scan of the head. 09/02/22 [fall risk evaluation] documented that the resident had a fall risk score of "22" which indicated that Resident #3 was at a "high risk" of falling. 09/06/22 at 7:21 AM [nursing note]- "At 5:15 AM resident was yelling and screaming. Staff observed resident crawling on floor ... head-to-toe assessment was done ...resident remains stable ..." 09/06/22 [fall risk evaluation] documented that the resident had a fall risk score of "23" which indicated that Resident #3 was at a "high risk" of falling. During a face-to-face interview on 09/08/22 at 4:00 PM, Employee #4 (Restorative Aide Director) stated that Residents #2 or #3 were not receiving	F 684		

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F 684	Continued From page 26 restorative nursing services because the rehabilitation department had not recommended them for the service. During a face-to-face interview on 09/08/22 at 4:30 PM, Employee #5 (Rehabilitation Director) stated that he had forgotten to refer Residents' #2 and #3 to restorative nursing. He then said he would refer the residents to the restorative nursing program on 09/08/22.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842	F842 1. Residents #4 and #7 currently reside in the facility. No ill effects are noted as a result of the deficiency. Resident #4's responsible party will be made aware of the involuntary seclusion incident by the Director of Nursing. Resident #7's face sheet was updated on 9/20/22 to accurately reflect the resident's power-of-attorney contact designation. 2. The Director of Nursing or designee will review the past 30 days of abuse allegations to ensure that the resident's responsible party was notified of the incident and that the information provided is documented in the medical record. The Administrator or designee will review the current residents' face sheets to ensure the residents' power-of-attorney designation is present if applicable.	11/21/22

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F 842	Continued From page 27 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842	3. The Director of Nursing or designee will in-service the licensed nurses that the resident's responsible party must be notified of any abuse allegations including involuntary seclusion and the notification must be documented in the medical record. The Administrator or designee will inservice the Unit Secretaries, Admissions Staff, and Social Work Staff that the resident face sheet must accurately reflect the resident's power-of-attorney designation. 4. The Director of Nursing or designee will audit abuse allegations to ensure that the resident's responsible party was notified and documented in the medical record weekly x 4, then monthly x 3 months. The Administrator or designee will audit 20% of the facility census to ensure the resident's face sheet accurately reflects the resident's power-of-attorney designation weekly x 4, then monthly x 3 months. Results of the audits will be submitted to the Quality Assurance and Performance Committee.	

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F 842	Continued From page 28 Based on observation record reviews and interviews, for two (2) of nine (9) sampled residents, the facility's staff failed to ensure a resident's medical records contained complete information provided to a resident's representative regarding her being involuntary secluded to her room by Employee #9; and (2) a resident's power-of-attorney information in her medical record (face sheet) was accurate. (Residents' #4 and #7). The findings included: 1. The facility's staff failed to ensure Resident #4's medical record contained complete information provided to her representative regarding her being involuntary secluded in her room by Employee #9. Resident #4 was admitted to the facility on 05/25/22 with multiple diagnoses including unspecified psychosis, altered mental status, generalized muscle weakness, and unsteadiness on feet. On 09/12/22, 09/14/22 and 09/15/22 starting at approximately 11:50 AM to 2:00 PM, Resident #4 was observed wandering in the hallway walking very fast from one end to the other. On 09/12/22 the resident was easily re-directed by staff to her room and assisted her with putting her shoes on. Although Resident #4 was easily redirected, the resident was not able to be interviewed because she was only oriented times one (name). Review of the resident's medical record revealed the following: 08/26/22 at 12:57 PM [Situation, Background,	F 842		

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F 842	Continued From page 29 Assessment and Request] documented, "Situation - writer was informed at about 12:25 PM that the resident's doorknob was found tied with a plastic trash bag to the hallway grab rail ...Assessment - involuntary seclusion ..." 08/26/22 at 10:41 PM [unit manager progress note] writer was informed at about 12:25 PM that resident's knob was tied with a plastic trash bag to hallway grab rail. When asked resident said I don't know. Interviewed and head to toe assessment done ...no distress, pain or discomfort noted ...RP (responsible party) daughter called [daughter's name] updated..." Review of the facility's investigative notes revealed Employee #9's (Certified Nursing Assistant) written statement signed on 08/26/22. The employee documented, "I was doing my last rounds and [Resident #4's name] was coming out naked so I closed her door and tied a plastic bag on the doorknob to prevent her from coming out of the room and walking around naked. After I was done with my rounds I forgot to untied [sp] the plastic bags from the doorknob." During a telephone interview on 09/12/22 at approximately 1:00 PM, Resident #4's representative (daughter) state that someone from the facility contacted her and told her, "Something occurred with your mom, we assessed her, and she is okay. The representative said when she asked what specially happened? The person, "They also could not give me any further information." When asked if she remembered who called her? The representative stated that she could not remember.	F 842		

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F 842	Continued From page 30 During a face-to-face interview on 09/12/22 at approximately 2:00 PM, Employee #11 (Unit Manager) stated she called and made the resident's representative (daughter) aware of the involuntary seclusion incident. When asked what did the word "update" mean in the progress note she wrote on 08/26/22? The employee said that it meant she made the resident's responsible part aware of the involuntary seclusion incident. 2.The facility's staff failed to ensure Resident 7's power-of-attorney information in her medical record (face sheet) was accurate. Resident #7 was admitted to the facility on 05/25/22 with multiple diagnoses including major depressive disorder, anxiety, and dependence on renal dialysis. During a face-to-face interview on 09/14/22 at 8:35 AM, Resident #7 stated, "I signed papers last month (August 2022) to have [name of power-of-attorney] assist me with certain things." A review of Resident #7's Annual Minimum Data Set (MDS) dated 08/22/22, showed the resident had a Brief Interview of Mental Status summary score of "14" which indicated the resident's cognitive functioning was intact.	F 842		