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	HFD02-0031	A. BUILDING: _____ B. WING _____	C 09/20/2022

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L 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, and DC00010975 were investigated during this survey. Deficiencies were cited related to the following investigations: DC00010871, DC00010956, DC00010958, DC00010974, DC00010973, and 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 CMS - Centers for Medicare and Medicaid Services	L 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.	

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L 000	Continued From page 1	L 000		

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
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen

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L 000	Continued From page 2 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	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;	L 051	L051 1.Residents #3 and #4 currently reside in the facility. No ill effects noted as a result of the deficiency. Resident #3's bed was lowered as per the individual care plan. Resident #4's care plan was updated to address the behavior of disrobing.	11/21/2022

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L 051	Continued From page 3 (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observations, record reviews and interviews, for two (2) of nine (9) sampled residents, the charge nurse failed to: (1) implement a person-centered comprehensive fall's care plan for Resident #3; (2) revise a comprehensive care plan to address Resident #4's behavior of disrobing. The findings included: 1. The facility's staff failed to implement the intervention to place Resident #3's bed in the lowest position to ensure safety and fall precautions, as outlined in the fall care plan initiated on dated 09/06/22. Resident #3 was admitted to the facility on 07/12/22 with multiple diagnoses, including generalized muscle weakness, lack of coordination, osteoarthritis, and epilepsy. During an observation on 09/12/22 at approximately 9:50 AM, Resident #3 was noted awake lying in bed. The resident's bed was in an elevated position. The resident's assigned nurse was outside the resident's room in the hallway at her medication cart and the assigned CNA (certified nursing assistant) was next door providing incontinent care for another resident.	L 051	2. The Unit Managers or designee will review the current residents in the facility to ensure that those with care plans for lowered beds have their beds in the lowered position, and that those with behavior of disrobing are care planned for the behavior. 3. The Director of Nursing or designee will in-service the nursing staff to ensure that those with care plans for lowered beds have their beds in the lowered position, and that residents with disrobing behavior have the behavior care planned. 4. The Director of Nursing or designee will audit the residents with care plans for lowered beds to ensure they have their beds in the lowered position, and that residents with behavior of disrobing have the behavior care planned 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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L 051	Continued From page 4 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 that the resident was not coded for falls before or after admission. Review of Resident #3's medical record showed the following: 09/06/22 at 5:43 AM [fall risk evaluation] documented that the resident had a fall risk score of "23" which indicated 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 ..." Review of Resident #4's following care plan dated 09/06/22: Focus area [Resident # 3's name] had an actual fall with no injury r/t (related to) poor balance, poor communication/comprehension due to dementia. The care plan had multiple interventions including place bed in lowest position for fall precaution and safety. During a face-to-face interview on 09/12/22 at 10:10 AM, Employee #12 (Certified Nursing Assistant) stated, "It was my fault. I left her bed elevate after feeding her breakfast. I just forgot to lower her bed low before I left to help another resident."	L 051		

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L 051	Continued From page 5 2. The facility's staff failed to develop a comprehensive care plan to address Resident #4's behavior of disrobing. Resident #4 was admitted to the facility on 05/25/22 with multiple diagnoses including unspecified psychosis and altered mental status. A review of an Admission Minimum Data Set (MDS) dated 06/01/22 revealed Resident #4 had a Brief Interview for Mental Status summary score of "2", which indicated the resident's cognitive function was severely impaired. Additionally, Resident #4 was not coded for behavioral symptoms not directed toward others such as disrobing in public. Review of the facility's investigative notes revealed a written statement signed by Employee #9's (Certified Nursing Assistant) 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 ..." 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 ... " During a face-to-face interview on 09/12/22 at	L 051		

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L 051	Continued From page 6 12:18 PM, Employee #11 (Unit Manager) reviewed Resident #4's comprehensive care plans and stated that she would update the resident's care plan to address her behavior of disrobing.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and	L 052	L052 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. 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.	11/21/22

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L 052	Continued From page 7 recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and interview, the facility's staff failed to sufficient time to provide restorative nursing services for two (2) of nine (9) sampled residents, as ordered by a physician (Residents' #2 and #3). The findings included: 1.Resident #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,	L 052	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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L 052	Continued From page 8 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 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	L 052		

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L 052	Continued From page 9 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." 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.	L 052		

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L 052	Continued From page 10 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 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.	L 052		
L 191	3231.2 Nursing Facilities A designated employee of the facility shall be assigned the responsibility for implementing and maintaining the medical records service. This Statute is not met as evidenced by: Based on observation record reviews and interviews, the facility's staff failed to ensure that residents medical records contained complete information provided to a resident's representative regarding her being secluded to her room involuntarily by a facility staff for one (1) of nine (9) sampled residents (Resident #4)	L 191	L191 1. Resident #4 currently resides 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 and a note detailing the information provided to the responsible party will be recorded.	11/21/22

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L 191	Continued From page 11 The findings included: 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, 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	L 191	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. 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 and information provided must be documented in the medical record. 4. The Director of Nursing or designee will audit abuse allegations to ensure that the resident's responsible party was notified and the information provided is documented in the medical record 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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L 191	Continued From page 12 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. 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.	L 191		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone	L 201		

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	HFD02-0031	A. BUILDING: _____ B. WING _____	C 09/20/2022

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L 201	Continued From page 13 number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition; (m)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo	L 201	L201 1. Resident #3 currently resides in the facility. No ill effects are noted as a result of the deficiency. Resident #3's Face Sheet was updated to accurately reflect the responsible party's contact information. 2. The Administrator or designee will audit the current resident face sheets for presence of responsible party contact information. 3. The Administrator of designee will in-service that admissions staff, social work staff, and unit secretaries on the importance of conducting a thorough patient registration to include responsible party contact information on the face sheet. 4. The Administrator or designee will audit 20% of resident face sheets 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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L 201	Continued From page 14 condition; (n)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q)The plan of care; (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on records review and interviews, the facility's staff failed to ensure a resident's face sheet included her mother's telephone number for one (1) of nine (9) sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on	L 201		

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L 201	Continued From page 15 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 black eye and stitches 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 ..." 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. A review of Resident #3's face-sheet showed her mother's phone number was not documented. During a telephone interview on 09/12/22 starting at 9:14 AM, the complainant stated the facility's staff failed to contact the family when the resident fell on 09/02/22, causing a left eye brow laceration that required stitches. During a face-to-face interview on 09/15/22 at	L 201		

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L 201	Continued From page 16 approximately 2:30 PM, Employee #2 (DON) stated that she would ensure the resident's facesheet was corrected immediately.	L 201		
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on records and interviews, for three (3) of nine (9) sampled residents, the facility staff failed to implement its Abuse, Neglect, and Exploitation policy by not identifying all witnesses (staff who worked the shift) in its investigative report 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	L 204	L204 1. Residents #4 and #9 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.	

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L 204	Continued From page 17 2022, the policy instructed staff to, "Identify and interviewing all involved persons ...and other who might have knowledge of the allegation ..." 1. The facility's staff failed to implement its Abuse, Neglect and Exploitation policy by not having documented evidence of interviews or obtaining written statements from all employees who worked when Residents #4 and #5 were secluded to their room by an Employee #9 (Certified Nursing Assistant). 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	L 204	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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L 204	Continued From page 18 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. 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.	L 204		

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L 204	Continued From page 19 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 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.The facility's staff failed implement its Abuse, Neglect and Exploitation policy by not having documented evidence of all employees who worked when Resident #8 had a verbal and physical altercation with Employee # 17 (Certified Nursing Assistant). 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)]	L 204		

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L 204	Continued From page 20 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 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	L 204		

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L 204	Continued From page 21 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 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.	L 204		
L 389	3254.5 Nursing Facilities The linen supply shall be at least three (3) times the amount that is needed for the licensed occupancy.	L 389		

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L 389	Continued From page 22 This Statute is not met as evidenced by: Based on record review and interviews, the facility's staff failed to have documented evidence of required linen levels. The findings include: Review of Compliant (DC00010958) dated 07/09/22 at 4:58 PM, documented, " ...On April 17th, 2022 (Easter) ... [Resident #7's name] asked for a towel, and there were no towels ..." During an interview on 09/15/22 at approximately 8:30 AM, Resident #7 stated when she had to go to doctor's appointment (06/23/22) a few months ago staff did not have a washcloth for her to wash-up, and she had to wash up with bathing wipes. During a telephone interview on 09/15/22 at approximately 9:30 AM, the complainant stated that on 06/23/22 the resident was unable to get a clean towel. An observation of the linen storage area on 09/15/22 at approximately 10:30 AM revealed multiple boxes and bags of new linen including washcloths and towels. A review of the environmental services documents lacked documented evidence of the amount of linen the facility had on-hand in June 2022. During a face-to-face interview on 09/15/22 at approximately 11:00 AM, Employee # 15 (Certified Nursing Assistant) stated that the facility had a linen shortage of wash clothes and towels for the past few months. The employee then reported that things were improving.	L 389	L389 1. The facility linen supply is currently 3 times the amount needed for the licensed occupancy. A log with the daily linen count will be initiated as evidence of sufficient linen supplies. 2. The EVS Director or designee will audit the linen supply to ensure there is 3 times the amount needed for the licensed occupancy. 3. The Administrator or designee will inservice the laundry staff on the necessity of maintaining linen 3 times the amount needed for the licensed occupancy. 4. The Administrator or designee will audit the linen supply weekly x 4, then monthly x 3 months. Results of the audit will be submitted to the Quality Assurance and Performance Committee.	11/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 389	Continued From page 23 During a face-to-face interview on 09/15/22 at approximately 1:00 PM, Employee 14 (Environmental Service Director) stated that the facility had an issue with a linen shortage previously, so they changed vendors and that issue had been resolved. The employee also said, "He did not keep a record of the amount of linen he had on hand, but he would moving forward."	L 389		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on an observation, record review and interviews, the facility's staff failed to have documented evidence Resident #7's room and bathroom was cleaned in an sanitary, orderly, comfortable and attractive manner on 04/17/22 and 06/23/22 for one (1) of nine (9) sampled residents. The findings included: 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	L 410	L410 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. 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.	11/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 410	Continued From page 24 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 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	L 410	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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	HFD02-0031	A. BUILDING: _____ B. WING _____	C 09/20/2022

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L 410	Continued From page 25 being cleaned on 04/17/22 and 06/23/22.	L 410		
L 529	3269.1l Nursing Facilities (l) To be free from mental or physical abuse; This Statute is not met as evidenced by: Based on observations, record reviews and interviews, the facility's staff failed to ensure two (2) of nine (9) sampled residents were free from mental or physical abuse (involuntary seclusion) (Residents' #4 and #5). The findings included: 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 ..."	L 529	L529 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. 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.	11/21/22

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L 529	Continued From page 26 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 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]	L 529		

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L 529	Continued From page 27 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]. 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	L 529		

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L 529	Continued From page 28 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 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]	L 529		

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L 529	Continued From page 29 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, 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	L 529		

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L 529	Continued From page 30 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.	L 529		