Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0027	A. BUILDING: ______ B. WING ______	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

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L 000	Initial Comments An unannounced Recertification Survey was conducted at this facility from May 16 - 30, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 173 and the survey sample included 41 residents. The following Facility Reported Incidents were investigated during this survey: DC00010784, DC00010794, DC00010998, DC00010942, DC00011067, DC00011232, DC00011509, DC00011520, DC00011746, DC00011818, and DC00011900. The following Complaint was investigated during this survey: DC00010368. Federal and/or Local deficiencies were cited related to the investigation(s) of DC00010942, DC00011067, and DC00011746. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. 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	L 000	**Preparation and execution of this plan of correction does not constitute Carroll Manor's admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Carroll Manor's obligations under federal and state law.**	

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L 000	Continued From page 1 CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue Dl - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources Hrs - Hours HS - hour of sleep HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP - Infection Prevention and Control Program LPN - Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M - Minute ML - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter	L 000		

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L 000	Continued From page 2 Mm/Hg - millimeters of mercury MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	L 000		
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on records review on May 24, 2023, at approximately10:00 AM, it was determined that facility staff failed to ensure that one (1) of five (5)	L 012		

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L 012	Continued From page 3 persons in charge, who is a certified food protection manager, obtained an updated District of Columbia Food Protection Manager Identification Card. The findings include: During a review of dietary records on May 24, 2023, at approximately 10:00 AM, one (1) of five (5) persons in charge did not have an updated, District-issued Food Protection Manager Identification Card. The Food Protection Manager Identification Card that was presented for review expired as of 08/31/2022. The 2012 District of Columbia Food Code, section 203.3 of chapter 2 states the following: 2012 District of Columbia Food Code 203 CERTIFICATION AND DISTRICT-ISSUED ID REQUIREMENTS -FOOD PROTECTION MANAGER, PERSON IN CHARGE 203.1 Each person in charge shall be certified by a food protection manager certification program that is accredited by the Conference for Food Protection Standards for Accreditation of Food Protection Manager Certification Programs. Such certified food protection managers shall be deemed in compliance with §201.2(b). 203.2 A person in charge who is a certified food protection manager as required in §203.1 shall be re-certified every three (3) years. 203.3 A person in charge who is a certified food	L 012	L012 I.**Corrective action for residents noted to have been affected by the deficient practice.** The Manager identified during survey will receive the Food Protection ID by 7/27/2023. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Manager will review the current dining services team to ensure that dietary managing staff have their Food Protection ID by 7/27/2023. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The Food Services Manager or Supervisor will audit new dining services managers who require Food Protection ID on a monthly basis to ensure that they obtain the required ID within 6 months. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed audit results and trends will be completed by the Dining Services Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **Completion Date**:7/27/2003.	7/27/2023 7/27/2023 7/27/2023 7/27/2023

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L 012	Continued From page 4 protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years. These observations were acknowledged by Employee #13 during a face-to-face interview on May 25, 2023, at approximately 11:00 AM.	L 012		
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; (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:	L 051		

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L 051	Continued From page 5 Based on record reviews and staff interviews, for six (6) of 41 sampled residents, the charge nurse(s) failed to review residents care plans to ensure they included appropiate goals and approaches to address: (1) a resident's choking incident. (2) a resident's second fall with injury. (3) a resident who was receiving hospice services. (4) a resident recent right femur (hip) fracture. (5) a resident who had a UTI. and (6) a resident who was receiving IV hydration. (Residents #6, 20, 28, 35, and #139, #375). 1.Facility staff failed to ensure that a charge nurse implemented nursing interventions on Resident #139's care plan after the Resident had a choking incident in the facility's first-floor dining room on 04/03/23. Resident #139 was admitted to the facility on 02/18/22 with diagnoses including: Alcohol Dependence with Alcohol-Induced Dementia, Delusional Disorders, Personal History of Other Mental and Behavioral Disorder, and Restlessness and Agitation. A review of Resident #139's medical record showed: A Nurses Note dated 04/02/23 at 4: 49 PM documented: During lunchtime, around 12:50 pm, I was in the dining room serving residents their meal and sitting with other residents. The Resident was seated at his seat, and the writer brought in his tray, opened his food, and went to go get his coffee. As the writer was fixing the coffee, he heard the Resident screaming and observed the Resident choking, started Heimlich Maneuver, and called for help; another nurse	L 051	**L051** **I.Corrective action for residents noted to have been affected by the deficient practice.** A)Resident #139's care plan was updated to include dysphagia and risk for aspiration on 5/24/2023. B)Resident #6's fall care plan was updated on 4/24/2023. C) Resident #375 was discharged on 4/28/2023. D) Resident # 35 was discharged on 5/17/2023. E) Resident #28's careplan was updated to include hip fracture repair on 5/21/2023. F) Resident #20's careplan was updated on 3/13/2023 to include UTI. **II. How will the facility identify other residents having the potential to be affected by the same deficient practice?** Other Current residents residing at the community have the potential to be affected by this deficient practice. The Unit Manager or designee will review the current resident care plans on or before 7/20/2023 for person-centered interventions to address falls, hospice contact information, and IV's and Infection. III.**The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.**	7/27/2023 7/27/2023 7/27/2023

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L 051	Continued From page 6 called for 911, Resident was still unresponsive ...The supervisor came in, and suctioning was initiated, with some food particles noted. 911 arrived at the unit ...Narcan was administered by 911, and the Resident was transferred via stretcher to {Local Hospital] ...Md called ...RR [Name of Representative] contacted." A Hospital Discharge Summary dated 04/08/23 documented: "Hospitalization Summary ...presented to the emergency room after a [incident] when he appeared to be choking followed by lethargy. Improved with Narcan, after which he became combative. UDS (urine drug screen) negative ..." "Discharge Instructions: Acute and chronic encephalopathy - no acute stroke fragment. Returned to baseline ...Dysphagia. Evaluated by speech and swallow. A diet modified to puree', thin liquids; Behavioral modifications while eating; 1:1 feeding assistance; Small bites/sips., slow rate; Feed only when awake/alert; oral care 3-4 x (times) per day; and Aspiration precautions ..." A Care Plan dated 04/08/23 with a Category: Functional/Rehab Potential ...Eating: I need assistance with meals and snacks ..." A Speech Therapy Initial Assessment dated 04/11/23: " ...Standardized Tests: Clinical swallow evaluation revealed moderate oropharyngeal dysphagia. Pt (patient) is edentulous and is currently downgraded to a puree diet, thin liquids with 1:1 feeding. Previously able to self-feed finger foods pr nursing...Goal: The patient/caregivers will use safety strategies for purees and thin liquids with 80% accuracy with 1:1 feeding when fully alert with verbal, tactile, and visual instruction/cues..."	L 051	The Staff education nurse or designee will re-educate current licensed nurses on or before 7/20/2023 on person-centered Care plans. Residents with new or changed status will be reviewed by the Interdisciplinary Team during the daily clinical meeting for person centered care plan interventions. During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with new or changed status for person centered care plan interventions. The review will be documented in the Resident's clinical record. The Unit Manager or designee will randomly review resident care plans on a monthly basis times 3 months to ensure that infection care plan, IVs, falls, and hospice are implemented. Findings from the review will be corrected by the Unit Manager or designee immediately. (L051 Continued on next Page)	

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L 051	Continued From page 7 During a face-to-face interview on 05/24/23 at 12:19 pm, Employee # 12 (First Floor Unit Manager) stated she was responsible for updating care plans, and she acknowledged that Resident #139's comprehensive care plan did not include the Resident's dysphagia and risk for aspiration after choking on 04/08/23. 2. Facility staff failed to revise the approaches/interventions on Resident#6's person-centered care plan after the Resident had a second fall and sustained an injury 04/22/23. Resident #6 was admitted to the facility on 12/07/22 with diagnoses including Heart Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Volume Overload, and Generalized Muscle Weakness. A Nurse's Note dated 03/28/23 at 3:41 pm documented: " ...At 11:30 nurse was called to [Resident #6's room] by assigned Certified Nurse Aide (CNA) that [Name of Resident #6] is on the floor. The nurse went to [pronoun] room and found Resident in a sitting position, leaning back on the commode ...RN and nurse assessed the Resident; no apparent injury was noted ...The Resident was encouraged to use the call light to call for help .... " A Nurse's Note dated 04/22/23 at 12:35 pm documented: ".....about 10:45 am, the writer's (writer's) attention was called to [the Resident's] room by the assigned CNA. Upon arrival to the room, [the] Resident was observed sitting on the floor with her hand over[pronoun] face and was noted with blood gushing out from the left side of[pronoun] head. Immediately, pressure was applied to the site ... MD (Medical Director) was	L 051	L051 (continued) **IV. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed care plan results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. V. **Completion Date** 7/27/2023	7/27/2023 7/27/2023

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L 051	Continued From page 8	L 051		

notified of an unwitnessed fall with a head injury. Order obtained to send (send) to the nearest ER (Emergency Room) for further evaluation ..."

A Care Plan revised on 04/22/23 documented: "Category: Falls ...Problem:
[Name of Resident#6] had a fall on 03/28/23. Goal: 1. [Resident #6's Name] will be free of injury related to falls over the next review period. Interventions: 1.PT/OT (Physical Therapy/Occupational Therapy) Screen s/p fall 3/28/23. 2) Ensure that residents wear non-skid socks ...Problem [Name of Resident#6] had a fall on 4/22/23. Goal: 1. [Resident #6's Name] will be free of injury related to falls over the next review period. Interventions: 1.PT/OT Screen s/p fall 4/22/23. 2) Ensure that the Resident wears non-skid socks ...Of note, the fall prevention interventions that facility staff added from the Resident's fall on 03/28/23 to the Resident's fall on 04/22/23 were the same. There was no documented evidence that facility staff updated or revised the interventions to prevent Resident #6 from sustaining another fall.

During a face-to-face interview on 05/26/23 at approximately 12:11 pm, Employee #7 (Unit Manager) acknowledged that facility staff should have updated and revised the fall prevention interventions on Resident # 6 comprehensive care plan after the Resident had a second fall on 04/22/23.

3. Facility staff failed to ensure that a charge nurse revised Resident #375's person-centered comprehensive care plan to include the name and phone number of the hospice agency after the resident was placed on hospice.

Resident # 375 was re-admitted to the facility on

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L 051	Continued From page 9	L 051		

12/07/22 with diagnoses including Alzheimer's Disease, Dementia, Peripheral Vascular Disease, Pathological Fracture of Left Femur, Psychosis Not Due to A Substance, Anorexia, Unspecified Pain and Pressure Ulcer of Sacral Region.

A review of Resident #375's medical record revealed:

A Nurse Note dated 02/23/23 3:11 pm documented: "Resident was admit[ted] to [Name of Hospice Agency] routine hospice code status DNR/DNI/DNH (do not resuscitate, do not intubate, do not hospitalize), D/C (discharge labs, weight(s) vital signs, continue routine medication and diet,"

A Long Term Care Billing Information Sheet showed that as of 02/23/23, Resident # 375 began to receive hospice services from [Name of Hospice agency], Hospice Social Worker and Hospice Chaplain visits as per order, and prn (as needed) Hospice volunteer visits as indicated ...".
A Physician's Order dated 02/24/23 at 11:00 am directed: "Admit to [Name of Hospice Agency] Code status DNR/DNI/DNH."

A Care Plan dated 03/08/23 documented: "Category: End of Life ...Problem: Hospice Services: Resident #375 will be free of pain and suffering and die a peaceful, dignified death ...Interventions: Hospice referral and services through review date. Hospice Nurse visits as per ordered with times per week with prn visits.

A progress note dated 03/20/23 at 2:43 pm: "Transfer Note: Resident is to be transferred to [2nd Floor Room] since [pronoun] is no longer an elopement risk ...is currently on hospice care with [Name of Hospice Agency] and [an] aide visit 2-3

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L 051	Continued From page 10 times weekly. " During a face-to-face interview on 05/26/23 at 2:14 pm, Employee # 12 (First Floor Manager) stated that Resident #375 was placed on hospice before moving to the second floor. The Employee then acknowledged that Resident #375's comprehensive care plan did not identify the hospice agency's name or the agency's telephone number. 4.The facility's staff failed to develop a care plan with goals and interventions to address Resident #28's recent hip fracture. Resident #28 was admitted to the facility on 02/10/23. The resident had a history of Right Femur Fracture, Abnormalities of Gait Mobility, Repeated Falls, Pain in Right Hip, Dementia, and Sever Protein-Calorie Malnutrition. A review of a quarterly minimum data set dated 02/02/23 documented the resident had a Brief Interview for mental Status summary score of "04" indicating Resident #28's had severely impaired cognitive status. The resident was not coded for wandering. In addition, the resident was coded for requiring supervision of one staff member for walking in room and walking in corridor. A review of the resident's medical record revealed a nursing progress note dated 03/03/23 at 7:11 AM documented, "At approx. 5:55 ...[Resident #28] said my leg hurting ... [pro-noun] was rubbing entire right leg esp (sp) right thigh and hip area with external rotation.....[Resident #28] was not able to explain what happen ....offered Tylenol	L 051		

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L 051	Continued From page 11	L 051		

for pain but [pro-noun] refused. Temperature 98.1, Respiration 20, Blood Pressure 165/84, Oxygen Saturation Rate 96% on Room Air ...911 called awaiting transfer."

A review of a re-admission nursing progress note dated 03/08/23 at 8:47 PM documented, " ... [Resident #28] was transferred to ER (emergency room) on 03/03/23 for c/o (complaint) RT. (right) hip pain. During hospital stay resident was found to have Right Intertrochanteric Femur fracture. Resident underwent surgery of Right ORIF (Open Reduction and Internal Fixation) Intertrochanteric Fracture ..."

A review of Resident #28's care plans showed there was no documented evidence that the charge nurse reviewed the resident's care plan to ensure appropiate goals and appropoaches were included to address Resident #28's right hip fracture.

During a face-to-face interview on 05/22/23 at approximately 2:00 PM, Employee #12 (Unit Manager/RN) stated that she did not develop a care plan for Resident #28's right hip fracture, but she provided staff education on how to care for the resident. When asked if she had documentation of the training she provided? Employee # 12 stated, "No".

5. Failed to develop a comprehensive care plans with measurable goals, timeframes, and approaches to address resident care concerns for diagnoses of UTI [Urinary tract infection] for Residents #20.

Resident #20 was admitted to the facility on 02/15/2018 with multiple diagnoses including Peripheral Vascular Disease, Hypertension,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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L 051	Continued From page 12	L 051		

Osteoarthritis, Hypercholesterolemia, Alzheimer ' s, and Major Depressive Disorder.

An Annual Minimum Data Set (MDS) dated 04/11/2023 showed that facility staff coded the following:

In section C BIMS (Brief Interview for Mental Status) C0500 coded "10" indicating moderately impaired cognition.

In Section I (Active Diagnoses), I2300 Urinary tract Infection (UTI) (last 30 days).

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

"03/08/2023 13:36 Resident was seen by [NP (nurse practitioner) name] with POA (power of attorney) [son] at the bedside. After discussing orders were written for CBC, CMP, and UA C&S in the AM 03/09/2023."

"03/10/2023 21:09 Resident lab result was reviewed by (NP name) she called later and gave an order for Ciprofloxacin 250mg POq12 hrs x 7 days for UTI, medication taken from entry box and given ..."

"03/14/202319:36 Resident urine culture result received (MD name) notified new order given to Discontinue Cipro250mg PO q12hrs, start Nitrofurantoin 100mg BID x 5 days for UTI Medication taken from entry box and given ..."

03/08/2023 10:24 [physician's order] Directed, "Check CBC, CMP in am, UA C+S straight catch if needed."

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L 051	Continued From page 13 03/10/2023 16:10 [Physician's order] Directed, "Cipro 250mg Po Q12 hrs x7 days for UTI." 03/14/2023 19:00 [Physician's order] Directed, "D/C [discontinue] Cipro 250mg start Nitrofurantoin 100mg BID x5 days for UTI." Review of the comprehensive care plan showed no care plan was developed with a category for Diagnosis of UTI. The evidence showed that Resident#20's comprehensive care plans lacked documented evidence of the category, goals, approaches, and interventions to address care for the resident diagnosis of UTI. A face-to-face interview was conducted on 05/25/2023 at 2:25 PM with Employee #17 (Nurse Manager) and she acknowledged the findings. 6. Facility staff failed to update the comprehensive care plan with goals and approaches that address the resident's recieving Intravenous Fluid. Residents' #35. Resident #35 was admitted to the facility on 04/17/2023 with the following diagnoses: Chronic Kidney Disease, Hypertension, Peripheral Vascular Disease, Heart failure, and Hyperlipidemia. A review of Resident #35's medical record showed: Reviewed Progress note dated 05/16/2023 11:55 showed, "Resident is alert and verbally responsive, no acute distress noted. She was seen by [NP (nurse practitioner) name] due to pus-like drainage reported coming from the right	L 051		

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L 051	Continued From page 14	L 051		

ischium wound ... after reassessment, orders were written to apply warm compression for 10 mins to the right ischium abscess twice daily times 2 days ... Insert IV [intravenous] and start D51/2 NS@75ml[milliliters]/hr[hour] 2L [liters], then repeat CBC [complet blood count], BMP [Basic Metabolic Panel] on Thursday 5/18/2023. ..."

Reviewed Progress note dated 05/16/2023 20:10 showed, " ... she was started on Sodium Chloride o.45% @75ml/hr at 3 pm while awaiting D51/2NS to be delivered. D51/2NS was received about 7:30pm and was started as ordered. IV infusing well. No infiltration was noted. ..."

Reviewed Progress note dated 05/17/2023 00:06 showed, " ... insert IV and start D51/2NSat 75ml/hrs x2L ... D51/2 NS not available in house, order given by NP to start sodium chloride 0.45% at 75ml while awaiting D51/2NS. A peripheral IV line inserted to the right arm and the resident started on IV fluids as ordered. ..."

A review of Resident #35's comprehensive care plan showed a Category area of Infection and IVs that lacked information that pertained to the goals, approaches, and iterventions for the care and treatment of the resident recieving intravenous fluid.

During a face-to-face interview conducted on 05/26/2023, at approximately 1:15 PM with Employee #17 (Nurse Manager), she acknowledged the findings.

[Cross-over DCMR 3210.4 (c)]

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L 052	Continued From page 15	L 052	**L052**	
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 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	L 052	**I.Corrective action for residents noted to have been affected by the deficient practice.** Resident #136 was re-educated on the smoking policy; care plan was updated; and his smoking materials were removed by the licensed nurse. Resident was also encouraged to participate in a smoking cessation program **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** Other current residents were educated on the smoking policy by the leadership team and no other smokers were identified. Other current resident rooms were also searched (with permission by the residents) and no smoking materials were found. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Current associates and residents were re-educated on the smoking policy on or before 7/27/2023 by the Nurse Educator or designee. The Executive Director shared the policy with resident representatives on 5/18/2023. **(L052 Continued on next page)**	7/27/2023 7/27/2023 7/27/2023

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L 052	Continued From page 16 him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review, and interviews, facility staff failed to ensure that sufficient nursing time was provided for : (1) Resident#136 to prevent an accident or injury, as evidenced by the resident's possession of smoking materials in the facility. (2) Resident #136 was admitted to the facility from the hospital on 01/20/22 with diagnoses including: Hemiplegia following Cerebral Infarct, Atrial Fibrillation, Essential Hypertension, Abnormal Levels of Serum Enzymes, and Anxiety Disorders. A review of Resident #136's medical record revealed the following: A Hospital Discharge Summary dated 01/20/22 that documented Discharge Diagnosis: Smoking Hx (History) ...Hospital Course: History of cigarette smoking- Nicotine patch d/c discharge as patient refusing ..." An Admission Assessment dated 01/20/22 at 7:51 pm documented that the Resident had no desire to smoke: " ...Smoking Evaluation: Resident desires to smoke(?): No." Of note, Resident #136's medical record lacked documented evidence that facility staff conducted any subsequent smoking evaluations/assessments for the Resident after admission.	L 052	L052 continued Interdisciplinary team has reviewed smoking policy and procedure and it is in compliance with the state regulation L052. Unit Manager or designee will make random rounds of resident rooms to ensure that residents do not possess smoking materials. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed rounds results and trends will be completed by the unit manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date:7/27/2023**	7/27/2023 7/27/2023

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L 052	Continued From page 17	L 052		

A review of the facility's "Smoking Policy -Residents" approved on 06/2022 documented: "Prior to, and upon admission, residents shall be informed of any limitations on smoking, including designated smoking areas ...The use of tobacco on property is restricted to designated resident smoking areas, which are located outside of the building ...The Resident should be evaluated on admission to determine smoking preference...The Resident's ability to smoke safely should be re-evaluated quarterly upon a significant change (physical or cognitive) or as determined by staff. The Resident's care plan will be updated accordingly ...Smoking-related privileges, restrictions, and concerns are noted in the care plan. Residents are not permitted to keep smoking materials, including lighters and matches with other residents ... Smoking is not permitted while oxygen is in use ..."

A review of Resident #136's comprehensive care plan, initiated on 01/20/22 and last updated on 05/0423, failed to address
the Resident's history of smoking or current use of tobacco.

A review of the Nurses' Notes from 03/21/23 to 05/18/23 lacked documented evidence that Resident #136 was a smoker or had smoking materials (cigarettes, lighter, matches) in [pronoun] current possession.
During a face-to-face interview on 05/18/23 at approximately 2:00 pm, Employee #3 (Assistant Director of Nursing/ADON) stated that no residents on the second floor or in the entire facility smoked.

During a face-to-face interview on 05/18/23 at 2:06 pm, Employee# 4 (Certified Nurse Assistant)/CNA), Employee stated that [pronoun]

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L 052	Continued From page 18	L 052		

had never observed any of the Residents smoking. About one month ago, while cleaning Resident #136's room, [pronoun] noticed a pack of cigarettes in a bag sitting on the windowsill of the Resident's room. The Employee reported that [she] notified a licensed nurse and left the cigarettes in the Resident's room. When asked which nurse was notified, the Employee stated that [pronoun] could not remember.

A review of Resident #136's entire medical record lacked documented evidence that after Employee #4 observed smoking materials in the Resident's room, that facility staff:
1) Reported the observation and investigated the incident;
2) Confiscated the cigarettes and other smoking material from the Resident or the Resident's room;
3) Supervised or monitored the Resident to ensure the Resident was not smoking in the facility; or
4) Updated the Resident's care plan.

During an observation and face-to-face interview on 05/18/23 at 2:20 pm, Resident #136 was lying on his bed. When asked if he smoked, the Resident said, "Yes, I used to smoke and drink every day. Now I smoke now and then. The last time I had a cigarette was last week. I do not smoke in the facility or on the premises. I do not share cigarettes with other residents. I buy cigarettes myself and smoke cigarettes when I am out with my family or friends. I know there is no designated area to smoke in the facility, and I know there is no smoking in the building because I have seen the signs at the front door." The Resident then stated that [pronoun] currently had cigarettes in [pronoun] possession and pointed to a bag on his windowsill. The Resident then

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L 052	Continued From page 19 opened the bag to show the surveyors a pack of Newport cigarettes. When asked if [pronoun] had a cigarette lighter in his possession, the Resident stated that [pronoun] did but did not show the cigarette lighter to the surveyors. Of note, Resident #136's room was close to three (3) residents receiving oxygen therapy. During a face-to-face interview on 05/18/23 at 3:03 pm with Employee #1 (Executive Director) and Employee #2 (Director of Nursing/DON), Employee #1 reiterated that, to their knowledge, the facility had no residents that smoke. When asked about the facility's smoking policy, Employee #1 stated, "If a resident is admitted and they smoke, we inform them that they cannot smoke onsite. We review our smoking policy included in the Residents' admission packets. We inform them that they are not allowed to have smoking materials in their possession for safety." The survey team then notified Employees #1 and #2 that Resident #136 was observed with smoking materials in [pronoun] and admitted to smoking. On 05/18/23 at 5:31 pm, Employee #1 reported that facility staff had spoken with Resident # 136, had confiscated the smoking materials from the Resident's room, and had re-educated the Resident about the facility's smoking policy.	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall	L 056		

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L 056	Continued From page 20	L 056		

Continued From page 20

be in addition to any coverage required by subsection 3211.4.

This Statute is not met as evidenced by:
Based on record review and staff interview, during a review of staffing [direct care per resident day hours], it was determined that the facility failed to meet the four and one-tenths (4.1) hours of direct nursing care per resident per day on 20 of 20 days reviewed and the 0.6 [six-tenths] hour for Registered Nurses /Advanced Practice Registered Nurse hours on 20 of 20 days reviewed in accordance with Title 22 DCMR Section 3211 Nursing Personnel and Required Staffing Levels.

The findings include:

According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six-tenths (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.

1.The facility failed to meet the minimum Registered Nurse/ Advanced Practice Registered Nurse rate of 0.6 [six-tenths] hours per resident per day on 20 of 20 days reviewed as outlined below:

September 20, 2022- 0.14 hours
November 17, 2022- 0.14 hours

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L 056	Continued From page 21 January 18, 2023 -0.10 hours February 23, 2023 - 0.20 hours February 24, 2023 0.25 hours February 25, 2023 0.25 hours February 26, 2023 0.15 hours February 27, 2023 0.15 hours February 28, 2023 - 0.15 hours March 9, 2023 - 0.04 hours April 15, 2023 - 0.27 hours April 16, 2023 - 0.27 hours April 24, 2023- 0.19 hours May 7, 2023 - 0.13 hours May 8, 2023 0.09 hours May 9, 2023 0.09 hours May 10, 2023 0.18 hours May 11, 2023 0.09 hours May 12, 2023 - 0.18 hours May 13, 2023 0.23 hours 2. The facility failed to meet the minimum direct nursing care staffing rate of four and one-tenths (4.1) hours per resident per day, for 20 of 20 days reviewed as outlined below: September 20, 2022- 3.2 hours November 17, 2022- 3.11 hours January 18, 2023, - 3.64 hours February 23, 2023 - 3.29 hours February 24, 2023 - 3.44 hours February 25, 2023- 2.71 hours February 26, 2023 - 2.41 hours February 27, 2023- 3.22 hours February 28, 2023 - 3.45 hours March 9, 2023 - 3.32 hours April 15, 2023 - 2.40 hours April 16, 2023 - 2.18 hours April 24, 2023 - 3.03 hours May 7, 2023 - 2.50 hours May 8, 2023 - 2.86 hours May 9, 2023 - 2.86 hours	L 056	L056 **I.Corrective action for residents noted to have been affected by the deficient practice.** The Facilities Attendance Policy was reveiwed with the Director of Nursing and Assistant Director of Nursing **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Recruiter will coordinate with Nursing Administration to assist with open positions. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Short term payment incentives options will be offered to attract nursing staff. Director of Nursing or designee will review daily staffing on a daily basis and utilize staffing call logs to assist with filling scheduling needs. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed reviews results and trends will be completed by the Director of Nursing or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date**:7/27/2023.	7/27/2023 7/27/2023 7/27/2023 7/27/2023

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L 056	Continued From page 22 May 10, 2023 - 3.01 hours May 11, 2023 - 2.80 hours May 12, 2023- 2.75 hours May 13, 2023 - 2.13 hours During the review of staffing on May 26, 2023, in the presence of Employee #1, which acknowledged the findings.	L 056		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to store and prepare foods in accordance with professional standards of practice for food services safety as evidenced by eight (8) of nine (9) four-inch-deep soiled bullet pans and two (2) of five (5) two-inch deep soiled bullet pans stored on a ready-for-use shelf, one (1) of one (1) six-pound, four-ounces can of Sysco Fancy Shredded Sauerkraut labeled with a best-by date of October 2022, six of six (6) six-pound, four-ounces cans of Jalapeno slices with a best-by date of January 21, 2023, and fire sprinkler blow off caps that were soiled with grease and/or foreign substances. The findings include: During a walkthrough of the facility's kitchen on May 16, 2023, at approximately 9:00 AM, the following observations were made:	L 099	**L099** **I.Corrective action for residents noted to have been affected by the deficient practice.** a. The stained bullet pans were cleaned by the dietary associate. b. The Fancy Shredded Sauerkraut was discarded by dietary staff c. The Jalapeno slices were discarded by the dietary staff d. The rubber blow off caps were dusted and cleaned by the dietary staff **II. How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Dining Services Manager made rounds on May 16, 2023 to ensure that outdated food items were discarded; pans are clean; and rubber blow off caps were dusted and cleaned. **(L099 continued on next page)**	7/27/2023 7/27/2023

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L 099	Continued From page 23 1. Eight (8) of nine (9) four-inch-deep bullet pans and two (2) of five (5) two-inch deep bullet pans stored in the designated clean, and ready for use area of the kitchen, were stained throughout. 2. One (1) of one (1) six-pound, four-ounces can of Sysco Fancy Shredded Sauerkraut stored in dry storage had a best-by date of October 2022. 3. Six of six (6) six-pound, four-ounces cans of Jalapeno slices stored in dry storage had a best-by date of January 21, 2023. 4. Rubber blow off caps attached to seven (7) of seven (7) fire sprinkler heads located above two (2) deep fryers, and the gas stove were soiled with dust and/or foreign substance. These observations were acknowledged by Employee #13 during a face-to-face interview on May 25, 2023, at approximately 11:00 AM.	L 099	**III. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur**. Kitchen staff was re-educated on the proper cleaning of pans, use date of food items; and the cleaning and dusting of the rubber blow off caps. The Dining Services Manager or designee will make rounds 3 times per week to ensure that outdated food items are discarded; pans are clean; and rubber blow off caps are dusted and cleaned. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V. Completion Date:7/27/2023.**	7/27/2023 7/27/2023 7/27/2023
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a) Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b) In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's	L 306	**L306** **I.Corrective action for residents noted to have been affected by the deficient practice.** The call bells in room #'s 129 and 455 were re-tested by the Facilities Manager and alarmed as intended. L306 (Continued on next page)	7/27/2023

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	HFD02-0027	A. BUILDING: ______ B. WING ______	05/30/2023

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L 306	Continued From page 24 room; (c) Be of a quality which is, at the time of installation, consistent with current technology; and (d) Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 43 resident's rooms that failed to initiate an alarm when tested. The findings include: During an environmental tour of the facility on May 22, 2023, at approximately 2:00 PM, call bells in two (2) of 48 resident's rooms (#129, #455) did not alarm when tested. These breakdowns could prevent or delay staff from responding to residents' needs in a timely manner. These observations were acknowledged by Employee #13 during a face-to-face interview on May 25, 2023, at approximately 11:00 AM.	L 306	**L306 (Continued)** II.**How will the facility identify other residents having the potential to be affected by the same deficient practice?** No other call bells were identified to be in need of repair **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The maintenance staff was inserviced on maintaining the call bell system in good working order by the Facilities Manager. The Maintenance manager or designee will randomly audit the resident call bells on a weekly basis time 3 months to ensure that they are in good working condition. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed audit results and trends will be completed by the Facilities Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date:**7/27/2023	7/27/2023 7/27/2023 7/27/2023 7/27/2023
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 observations and interview, it was determined that facility staff failed to provide	L 410		

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L 410	Continued From page 25 housekeeping services necessary to maintain a safe, and comfortable environment, as evidenced by privacy curtains that were hanging loose, detached from curtain hooks, in 75 of 192 residents' rooms. The findings include: During a life safety walkthrough of the facility on May 19, 2023, between 9:15 AM, and 11:30 AM, privacy curtains in residents' rooms were hanging loose off curtain tracks, and detached from curtain hooks on all occupied floors: Fifth floor: 35 of 48 residents' rooms Fourth floor: 18 of 48 resident's rooms Third floor: unoccupied Second floor: 17 of 48 residents' rooms First floor: five (5) of 48 residents' rooms. These observations were acknowledged by Employee #11 during a face-to-face interview on May 19, 2023, at approximately 2:00 PM.	L 410	L410 **I.Corrective action for residents noted to have been affected by the deficient practice.** The Environmental Services Manager made rounds of the curtains of occupied resident rooms on 5/20/3023. Curtains that were detached from curtain hooks were re-attached immediately by the EVS manager. II.**How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Environmental Services Manager made rounds of the curtains of occupied resident rooms on 5/20/2023. Curtains that were detached from curtain hooks were re-attached immediately by the EVS manager. **IV.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The Environmental Services manager or Designee will re-educate housekeeping staff on or before 7/27/2023 on maintaining privacy curtains on hooks. . The Environmental Services Manager or designee will randomly make rounds on a weekly basis times 3 months to ensure that privacy curtains are attached on hooks. Findings from the review will be corrected by the EVS manager or designee immediately. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed rounds results and trends will be completed by the Environmental Services Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date**:7/27/2003.	7/27/2023 7/27/2023 7/27/2023 7/27/2023 7/27/2023
L 534	3270.1 Nursing Facilities A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)). This Statute is not met as evidenced by:	L 534		

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L 534	Continued From page 26 Based on record reviews and staff interviews for two (2) out of 41 sampled residents, facility staff failed to provide notification to Residents' representatives that included the facility's bed hold policy or the number of bed hold days available for each Resident when they transferred to the hospital. 1. Resident #94 was admitted to the facility on 11/23/22 with diagnoses including: Cerebral Infarct, Metabolic Encephalopathy, Altered Mental Status, Generalized Muscle Weakness, and Age-Related Cognitive Decline. A review of Resident #94's medical record showed: A Quarterly Minimum Data Set(MDS) assessment dated 02/28/23 showed that the Resident had severely impaired cognition, exhibited trouble falling asleep or sleeping too much for 2-6 days poor appetite or overeating for 7-11 days, required extensive assistance for assisted daily living skills, (transfers. Eating, grooming, toileting, personal hygiene). A Nurses Note on 04/18/23 at 8:55 am documented, " ...around 10:00 am resident('s) son came to the nurse's station and said sister wanted to speak to doctor.....resident ('s) daughter) called and stated, 'You need to call wheelchair transportation, so I can take my mother to the ER cause she is going downhill by the hour" ... [Physician's Name] was informed of the Resident's daughter's request to transfer the Resident to the nearest ER for further evaluation.. [Physician's Name] give (gave) an order to transfer the Resident to the nearest ER. Of note, there was no documented evidence that Resident	L 534	L534 **I.Corrective action for residents noted to have been affected by the deficient practice.** Resident #139's and resident #94's representative was provided a copy of the bedhold policy on 6/26/2023. II.**How will the facility identify other residents having the potential to be affected by the same deficient practice?** A copy of the bedhold policy was provided to current residents by the Activities Staff on 6/26/2023. A copy of the bedhold policy was also emailed/ and mailed to current resident representatives by the Executive Director via email and letter on 6/26/2023. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The staff education nurse or designee will re-educate the licensed nurses , social workers and admissions staff on providing residents and/or resident representatives a copy of the bedhold policy on admission, hospital discharge, and therapeutic leave. IDT notes will be reviewed **(L534 Continued on next page)**	7/27/2023 7/27/2023 7/27/2023

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L 534	Continued From page 27 #94's Representative provided the bed hold policy. A Department of Health (DOH) Notice of Discharge Transfer or Relocation Form dated 04/18/23 at 4:07 pm documented:" ...This proposed action is an "a) Transfer - Hospital/Rehab facility/ Nursing home (2) Must list the specific reason(s) for the action: Resident was transferred to ER due to change in medical condition ...(5) If you are being transferred to a hospital or the transfer is for therapeutic leave, attached is the facility's bed hold policy. Your available number of bed hold days is: "N/A" In addition, there was no copy of the facility's bed hold policy attached to the form. A review of Resident #94's medical record lacked documented evidence that facility staff provided the facility's bed hold notice to the Resident or their representative, which included how long the facility would hold the bed, how the Resident or their Representative could make reserve payments and the conditions upon which the Resident could return to the facility. During a face-to-face interview on 05/26/23 at 2:54 pm, Employee #19 (Director of Social Work) stated that the family chose to have Resident #94 transferred to the hospital. The Employee then acknowledged that the "Notice of Discharge Transfer or Relocation Form" did not indicate the number of bed hold days available to the Resident and acknowledged no bed hold policy was attached to the notice. 2. Resident #139 was admitted to the facility on 02/18/22 with diagnoses including: Alcohol Dependence with Alcohol-Induced Dementia, Delusional Disorders, Personal History of Other	L 534	L534 Continued by the Interdisciplinary Team during the daily clinical meeting for compliance with providing a copy of the Bedhold policy (including bedhold days) to residents and or resident representatives on admission, hospital discharge and Therapeutic leave. Findings from the review will be corrected immediately by the Unit Manager or Designee. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date**:7/27/2023.	7/27/2023 7/27/2023

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L 534	Continued From page 28	L 534		

Mental and Behavioral Disorders, and Restlessness and Agitation.

A review of Resident #139's medical record showed:

An Annual Minimum Data Set (MDS) Assessment dated 02/21/23 showed that the Resident had severely impaired cognition, required supervision for walking in the corridor and the room, locomotion on the unit, and eating, used a wheelchair for mobility, and had no swallowing disorder.

A Nurses Note dated 04/02/23 at 4: 49 PM documented: "During lunchtime, around 12:50 pm, I was in the dining room serving residents their meal and sitting with other residents. The Resident was seated at [pronoun] seat, and the writer brought in [pronoun] tray, opened [pronoun] food, and went to go get [pronoun]coffee. As the writer was fixing the coffee, [pronoun] heard the Resident screaming and observed the Resident choking, started Heimlich Maneuver, and called for help; another nurse called for 911, Resident was still unresponsive ...The supervisor came in, and suctioning was initiated, with some food particles noted. 911 arrived at the unit ...Narcan was administered by 911, and the Resident was transferred via stretcher to [Local Hospital] ...MD (Medical Doctor) called ...RR [Name of Representative] contacted."

A Department of Health (DOH) Notice of Discharge Transfer or Relocation Form dated 04/03/23 at 10:12 am documented: " ...This proposed action is an a) Transfer - Hospital/Rehab facility/ Nursing home (2) Must list the specific reason(s) for the action: Change in medical status. RR [Name of Representative]

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L 534	Continued From page 29 informed of transfer and change in medical condition ...(5) If you are being transferred to a hospital or the transfer is for therapeutic leave, attached is the facility's bed hold policy. Your available number of bed hold days is: "N/A." In addition, there was no copy of the facility's bed hold policy attached to the form. A review of Resident #139's medical record lacked documented evidence that facility staff provided the facility's bed hold notice to the Resident or their Representative, which included how long the facility would hold the bed, how the Resident or their representative could make reserve payments and the conditions upon which the Resident could return to the facility. During a face-to-face interview on 05/26/23 at 2:54 pm, Employee #19 (Director of Social Work) stated that facility staff provided Resident #139's Representative with the Notice of Discharge Transfer or Relocation Form and the form. The Employee then acknowledged that the notice did not indicate the number of bed hold days available to the Resident and had no bed hold policy attached.	L 534		