STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	C 11/16/2022

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ASCENSION LIVING CARROLL MANOR	725 BUCHANAN ST., NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint/facility reported incidents survey was conducted at this facility from October 26, 2022 to November 16, 2022. Survey activities consisted of observations, record review, and resident and staff interviews. The facility's census during the survey was 162 and the sample included 19 residents. Complaints DC00011088, DC00010251 ,DC00010417, DC00010466, DC00010722, and DC00010842 and facility reported incidents DC00010310, DC00010385, DC00010386, DC00010413, DC00010431, DC00010549, DC00010549, DC00010555, DC00010619, DC00010658, DC00010695, DC00010696, DC00010762, DC00010794, DC00010827 , DC00010829, and DC00011009, were investigated during this survey. Deficiencies were cited related to the investigation of DC00010310, DC00010417, DC00010549, DC00010555, DC00010619, DC00010827, DC00010829,DC00010842 and DC00011009. 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. During the survey, actual harm level deficiencies were identified at: F686 for Resident #2 and F689 Resident #1. The following is a directory of abbreviations and/or acronyms that may be utilized in the report:	F 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.**	1/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	1-23-2023

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

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F 000	Continued From page 1	F 000		

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
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)

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F 000	Continued From page 2 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 PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		

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F 656	Continued From page 3 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged	F 656	F 656 **I. Corrective action for residents noted to have been affected by the deficient practice.** A) Resident #1 was discharged on 12-25-2021. B) Resident #5's Care plan was updated on 1/3/2022 to include non-compliance with maintaining her bed in the lowest position by the unit manager. C) Resident # 9's fall care plan was reviewed and revised on 1-4-2022 by the unit manager. **II. How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Unit Manager or designee will review the current resident care plans on or before 1/26/2023 for person-centered interventions to address falls and behaviors to include not calling for assistance **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 licensed nurses on or before 1/26/2023 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.	1/26/23 1/26/23 1/26/23

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F 656	Continued From page 4 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, for three (3) of 19 sampled residents, the facility's staff failed to: develop a care plan to outline how staff were to address Resident #1's behavior of refusing to call for assistance with ambulating and transferring, subsequently, the resident had multiple falls, including a fall resulting in a major injury on 11/18/21; and implement the "Falls" care plan for Residents' #5 and #9, as evidence by not placing bed in lowest position while in bed or placing mats on both sides of the bed while the resident was in the bed. The findings included: 1.The facility's staff failed develop a care plan to outline how staff were to address Resident #1's behavior of refusing to call for help with ambulating and transferring, subsequently, the resident had multiple falls, including a fall resulting in a major injury on 11/18/21. Resident #1 was admitted to the facility on 05/13/21. The resident had a history of multiple diagnoses including history of falls, muscle weakness, generalized osteoarthritis, age-related debility, hypertension and epilepsy. Continued review of the medical record revealed a history and physical (dated 02/27/21) from a nursing home the where Resident #1 previously resided that documented, "[Resident #1's] CT was negative for cranial abnormalities .... However, review of the facility's face sheet documented the	F 656	F656 (continued) 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 falls and behavior care plans are implemented related to beds in the lowest position and not calling for assistance. Findings from the review will be corrected by the Unit 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 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. **Completion Date**:1/26/2023	1/26/23

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F 656	Continued From page 5	F 656		

resident had a new diagnosis on 12/02/21 of trauma subdural hematoma without loss of consciousness.

A review of the District of Columbia's complaint intake #DC00010417 documented, Did the [resident] suffer any physical injuries? Yes, brain clot surgery [local hospital's name] 11/19/21 ... Complaint: 09/18/21- first fall ...explanation of injury didn't match what I expected when I saw him [Resident #1] in a video chat. 10/23/21- he [Resident #1] fell again not going to hospital ...11/18/21 he fell again doctor wants him to go to the hospital ...admitted and had surgery [left decompressive hemi-craniotomy] on 11/19/21 ...three falls are two too many should have had a better safety plan for patients [residents]. He came their [there] with a history of fall from 1/2021 ...not sure how many other times he fell not witnessed [brain blood] clot is [was] older and during the time he was in the nursing home.

Review of the policy tilted, Fall Policy with a last approval date of 01/2022 instructed staff complete the Hendrich II Fall Risk (or similar fall risk evaluation) during admission and quarterly ...

Review of medical record showed the following:

05/13/21 - The record lacked documented evidence the facility's staff completed a Hendrich II Fall Risk (or similar fall risk evaluation) during the resident's admission.

08/10/21- [Quarterly Minimum Data Set] documented, under Section C (Cognitive Pattern) Resident #1 had a Brief Interview for Mental Status summary score of "9", which suggested that the resident had a moderately impaired

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F 656	Continued From page 6	F 656		

cognitive status. Under section E (Behavior)- the resident was not coded for rejection of care. Under section G (Functional Status) the resident was coded for needing extensive physical assistance from one staff person for transfers between surfaces and toilet use, the resident required supervision from one staff member for walking in his room. And used an assistive device (walker) for mobility. Under Section J (Health Condition) the resident was coded for not having any fall since admission. Under Section O, the resident was not coded for receiving physical or occupational therapy services, And Under Section P (Restraints and Alarms) the resident was not coded for using any restraints or alarms.

08/01/22 to 08/31/22- the record lacked documented evidence the facility's staff completed a quarterly Hendrich II Fall Risk (or similar fall risk evaluation).

09/18/21 at 4:46 PM [Nursing Progress Note (1st documented fall)] documented, "at about 4:30 PM resident was observed on the floor in a supine position in the hallway in front of his room with his walker close by. Resident was observed walking in the hallway towards his room then tripped and fell. Resident stated that he went to get a blanket...tripled [tripped] on his walker and fell. Sustained skin tear to right upper eyelid, swollen measured 3 cm (centimeter) X 0.6 (cm) with minimal bleeding, pressure and ice applied. Resident complained of pain on right eye lid. Dr notified ...transfer to ER for further evaluation and treatment ..."

09/18/21 at 5:37 PM [Hendrich ll] had a score of "7" indicating the resident was at a high risk for having falls.

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F 656	Continued From page 7 09/19/21 10:49 AM [Hospital Discharge Summary] documented, reason for visit- fall and head injury. Diagnoses - multiple closed fractures of facial bone, subdural hematoma, facial hematoma, and facial laceration ...you have been seen for a subdural hematoma. On your CT scan it does not look recent and was not caused by today's fall. It was probably from another fall or minor injury at some point in the last few weeks or months ... 09/19/21 at 1:55 PM [Nursing Progress Note] documented, resident returned to the facility at 12:00 noon from [local hospital's name] where he was transferred after being observed on the floor ...He is alert and verbally responsive ...has periods of confusion ...steri-strips noted to the lateral area of right brow with no active bleeding, no swelling, no bone protrusion. Discoloration also noted especially around the right eye and right lower eyelid area ... 09/19/21 [Hospital After Visit Summary] documented, "reason for visit- fall and head injury. Diagnoses - multiple closed fractures of facial bone, subdural hematoma, facial hematoma, and facial laceration ...you have been seen for a subdural hematoma. On your CT (computerized tomography) scan it does not look recent and was not caused by today's fall. It was probably from another fall or minor injury at some point in the last few weeks or months ..." 10/23/21 at 10:41 PM [nursing progress note (2nd documented fall)]- at 10:20 PM writer was called by assigned CNA (certified nursing assistant) to report an unwitnessed fall, upon arrival to residents room, resident was found in a sitting	F 656		

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F 656	Continued From page 8	F 656		

position by his chair in his room, when asked what happened stated, "I was trying to get up" [but] didn't give any other information ...head to toe assessment done ...no acute distress ...initiated neuro-checks ...alert but oriented X1 ...educated to always call for assistance and verbalized understanding ...

11/02/21 [Quarterly Minimum Data Set] documented, under Section C (Cognitive Pattern) Resident #1 had a Brief Interview for Mental Status summary score of "4", which suggested that the resident had a severely impaired cognitive status. Under section E (Behavior)- the resident was coded for rejection of care behavior that occurred 1 to 3 days a week. Under section G (Functional Status) the resident was coded for needing extensive physical assistance from one staff person for transfers between surfaces and toilet use, the resident required supervision from one staff member for walking in his room. And used an assistive device (walker) for mobility. Under Section J (Health Condition) the resident was coded for having one (1) fall with no injury since his admission. Under Section 0 the resident was the resident was coded for receiving occupational therapy services. And, Under Section P (Restraints and Alarms) the resident was not coded for using any restraints or alarms.

11/17/22 at 11:50 PM [Professional Communication Form] documented, " ...fall ...resident hit his head ... temperature 97.1, pulse 56, respirations 20, blood pressure 108/62, pulse ox 98% on room air ...resident was more confused, change in behavior, insomnia ...transfer to hospital ...

11/18/21 at 3:08 AM [Nursing Note] documented,

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F 656	Continued From page 9	F 656		

" ...at 11:50 PM CNA (certified nursing assistant) called to this write's attention and reported resident was observed on the floor ...resident was lying on the floor near his bed, [resident's] head was very closed (sp) to the dresser, on assessment noted on the top of his head skin was scrapped, resident was aert [alert] and verbally responsive, [Resident #1] stated [he was] trying to get his socks.

11/18/21 at 5:41 AM [Supervisor Nursing Note] documented," called received for 2nd Floor charge nurse at 11:50 PM that resident was observed lying on the floor close to dresser at the foot of the bed ...upon arrival, resident observed in bed resting, with abrasion measured 1 cm (centimeter) X 2 cm not at top of his head ...resident stated, "I was trying to get my socks from the dresser ...for work ...then I fell , bending down ...and hit my head on the dresser ...head to toe assessment completed ...resident denied pain. Neurological assessment implemented and no changes from resident baseline ...

11/20/21 at 1:39 PM [Nursing Progress Note] documented, " ... the ER (emergency room) nurse informed writer that resident was admitted [to] ...medical surgical ICU (intensive care unit) on 11/18/21, and ICU nurse informed writer that there was no discharge plan for resident yet."

12/02/21 at 7:59 PM [Nursing Progress Note] documented, "resident ...re-admitted to facility at about 2:30 PM from [local hospital's name] after being treated for subdural hematoma evacuation after a fall ...he is alert, awake, oriented to self ...resident was re-admitted to the unit with diagnoses of subdural hemorrhage ...left side of head surgical site sutures intact, dry and healing

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F 656	Continued From page 10 progresses well ..." 12/02/21 [Hospital Discharge Summary]-"CT head shows bilateral subdural hematomas. Pt taken to the operating room for left decompressive hemi-craniotomy for evacuation of subdural hematoma. 11/19/21- admitted to surgical intensive care unit status-post fall with bilateral SDH L > R with left to right shift. Radiology review details shows ...Bilateral subdural hematoma (subacute/chronic with questionable acute superimposed subarachnoid hemorrhage versus artifact ...There is a mild rightward midline shift ...Discharge Diagnosis - Subdural Hemorrhage present on admission." During a telephone interview on 10/31/22 starting at 12:14 PM, the resident's physician stated that the resident failed to call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help. When we have patients with dementia, they may refuse care (call for assistance from staff). During a face-to-face interview on 10/31/22 starting a 12:20 PM, Employee #2 (DON) was asked, did Resident #1 have a care plan to address behavior of refusing to call staff for assistance when ambulating or transferring? Employee #2 failed to provide an answer. Please cross reference 483.25 Quality of Care F689 2. The facility's staff failed to implement the "Falls" care plan for Residents #5 as evidence by not placing bed in lowest position while in bed;	F 656		

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F 656	Continued From page 11	F 656		

and not having the bed in the lowest position and having mats on both sides of the bed when Resident #9 was in bed.

2a.Resident #5 was admitted to the facility on 01/23/15. The resident had a history of multiple diagnoses including transient ischemic attack, repeated falls, and abnormalities of gait and mobility.

Review of the District of Columbia's Intake Information form #DC00011009 dated 09/30/22 documented, " [At 8:00 AM ...Resident #5's name was observed lying on the floor beside her bed on her right side with both of her legs stretched out ...alert, oriented to name, place, and time....reported she rolled out of the bed to the floor and refused hitting her head .... At 9:30 AM resident noted lethargic and difficult to arouse ...transferred to [local hospital's name].... "

Review of a quarterly Minimum Data Set dated 09/20/22 documented, Under Section C (Cognitive) the resident had a Brief Summary Score of "11" indicating the resident was intact cognitively. Under Section E (Behavior) the resident was not coded for rejection of care. Under Section G (Functional Status) the resident was coded for requiring extensive assistance from two or more staff members for bed mobility. Under Section J (Health Condition) the resident was coded for have one fall since admission. Under Section O (Special Treatment, Procedures, and Programs) the resident was coded for receiving occupational therapy services, and Under Section P (Restraints and Alarms) the resident was not coded for using physical

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F 656	Continued From page 12	F 656		

restraints or alarms.

An observation was conducted at 10:30 AM on 11/10/22 revealed Resident #5 was lying in bed, awake in a supine position, head of bed elevated at a 45-degree angle, and quarter side rails in up position. Employee #13 was called to the bedside. The employee lowered the bed and stated, "She is a fall risk and it's not safe to leave her bed elevated that high. The staff may have left the bed elevated when she was eating."

Please cross reference (483.25 Quality of Care F689)

2b.Resident #9 was admitted to the facility on 04/25/08. The resident had multiple diagnoses including history of falls, generalized muscle weakness, and altered mental status.

Review of District of Columbia's Intake Information #DC00010310 dated 10/15/21 stated, "[Resident #9 was on the floor face down ...small amount of blood ...close to mouth ...transferred ... to [local hospital's name] ..."

Review of a Quarterly Minimum Data Set dated 08/23/22documented, Under Section C (Cognitive Pattern) the resident was coded with having problems with short/long term memory, recall memory, and severely impaired with daily decision making, Under Section E (Behavior) the resident was not coded for rejection of care. Under Section G (Functional Status) the resident was coded for requiring extensive assistance form two or more staff for bed mobility, Under Section J (Health Condition) the resident was not coded for falls history of falls or falls since admission, Under Section O (Special Treatment,

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	095034	A. BUILDING _____ B. WING _____	C 11/16/2022

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F 656	Continued From page 13 Procedures, and Programs) the resident was coded for receiving occupational therapy services, and Under Section P (Restraints and Alarms) the resident was not coded using restraints or alarms. Review of Resident #9's care plan dated 10/14/21 showed the following: Problem [Resident #9's name] has potential for falls related to immobility/twitching body movement/use of cardiac medication/cognitive impairment. Further review of the care plan showed multiple interventions including floor mats on both sides of the bed when residents is in bed. An observation was conducted at 12:55PM on 10/26/22 revealed Resident #9 was in bed, sleeping in supine position, bed elevated, and not having mats on either side of the bed. Employee #15 (RN) was called to the bedside, she lowered the bed and stated, "I'm not sure if staff was in here earlier doing something." During a face-to-face interview on 10/26/22 at 2:52 PM, Resident #14 (CNA) stated, "I should have left her bed in the low position with mats on both sides of the bed, but I forgot when I had to take another resident to church." The employee also said that they use the mats and lower the resident's bed because the resident was a fall risk.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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F 684	Continued From page 14 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 19 sampled residents, the facility staff failed to: have documented evidence Resident #1, who had a recent fall with major injury (subdural hematoma), was monitored hourly as outlined in his care plan; apply cold compresses to Resident #6's right eye as ordered. (Residents' #1 and #6). The findings included: 1. The facility staff failed to have documented evidence Resident #1, who had a recent fall with major injury (subdural hematoma), was monitored hourly as outlined in his care plan. Resident #1 was admitted to the facility on 05/13/21. The resident had a history of multiple diagnoses including history of falls, muscle weakness, generalized osteoarthritis, age-related debility, hypertension, and epilepsy. Continued review of the medical record revealed a history and physical (dated 02/27/21) from a nursing home the where Resident #1 previously resided that documented, "[Resident #1's] CT was negative for cranial abnormalities .... However, review of the facility's face sheet documented the resident had a new diagnosis on 12/02/21 of trauma subdural hematoma without loss of consciousness. Review of the resident's medical record showed the following:	F 684	F684 I.**Corrective action for residents noted to have been affected by the deficient practice.** A) Resident #1 was discharged on 12-25-2021. B) Resident #6 was discharged on 08-18-2022. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The unit manager or designee will review the documentation of treatment from incidents and accidents of current residents on or before 1/26/2023. **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 on following physician orders on treatments as prescribed, accurately documenting ordered treatment in the resident medical records, and implementing intervention outlined in the resident's person-centered careplans on or before 1/26/2023. The Unit Manager or designee will review incidents and accidents during the clinical huddle 3x's per week times 3 months to ensure that ordered treatment is documented in the medical record.	1/26/23 1/26/23 1/26/23

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F 684	Continued From page 15 11/02/21 [Quarterly Minimum Data Set] documented, under Section C (Cognitive Pattern) Resident #1 had a Brief Interview for Mental Status summary score of "4", which suggested that the resident had a severely impaired cognitive status. Under section E (Behavior)- the resident was coded for rejection of care behavior that occurred 1 to 3 days a week. Under section G (Functional Status) the resident was coded for needing extensive physical assistance from one staff person for transfers between surfaces and toilet use, the resident required supervision from one staff member for walking in his room. And used an assistive device (walker) for mobility. Under Section J (Health Condition) the resident was coded for having one (1) fall with no injury since his admission. Under Section 0 the resident was the resident was coded for receiving occupational therapy services. And, Under Section P (Restraints and Alarms) the resident was not coded for using any restraints or alarms. 11/17/22 at 11:50 PM [Professional Communication Form] documented, " ...fall ...resident hit his head ... temperature 97.1, pulse 56, respirations 20, blood pressure 108/62, pulse ox 98% on room air ...resident was more confused, change in behavior, insomnia ...transfer to hospital ... 11/18/21 at 3:08 AM [Nursing Note] documented, " ...at 11:50 PM CNA (certified nursing assistant) called to this write's attention and reported resident was observed on the floor ...resident was lying on the floor near his bed, [resident's] head was very closed (sp) to the dresser, on assessment noted on the top of his head skin was scrapped, resident was aert [alert] and	F 684	F684 (Continued) Findings from the review will be corrected by the Unit 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 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**: 1/26/2023.	1/26/23

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F 684	Continued From page 16	F 684		

verbally responsive, [Resident #1] stated [he was] trying to get his socks.

11/18/21 at 5:41 AM [Supervisor Nursing Note] documented," called received for 2nd Floor charge nurse at 11:50 PM that resident was observed lying on the floor close to dresser at the foot of the bed ...upon arrival, resident observed in bed resting, with abrasion measured 1 cm (centimeter) X 2 cm not at top of his head ...resident stated, "I was trying to get my socks from the dresser ...for work ...then I fell, bending down ...and hit my head on the dresser ...head to toe assessment completed ...resident denied pain. Neurological assessment implemented and no changes from resident baseline ...

11/20/21 at 1:39 PM [Nursing Progress Note] documented, " ... the ER (emergency room) nurse informed writer that resident was admitted [to] ...medical surgical ICU (intensive care unit) on 11/18/21, and ICU nurse informed writer that there was no discharge plan for resident yet."

12/02/21 at 7:59 PM [Nursing Progress Note] documented, "resident ...re-admitted to facility at about 2:30 PM from [local hospital's name] after being treated for subdural hematoma evacuation after a fall ...he is alert, awake, oriented to self ...resident was re-admitted to the unit with diagnoses of subdural hemorrhage ...left side of head surgical site sutures intact, dry and healing progresses well ..."

12/02/21 [Hospital Discharge Summary]-"CT head shows bilateral subdural hematomas. Pt taken to the operating room for left decompressive hemi-craniotomy for evacuation of subdural hematoma. 11/19/21- admitted to

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F 684	Continued From page 17	F 684		

surgical intensive care unit status-post fall with bilateral SDH L > R with left to right shift. Radiology review details shows ...Bilateral subdural hematoma (subacute/chronic with questionable acute superimposed subarachnoid hemorrhage versus artifact ...There is a mild rightward midline shift ...Discharge Diagnosis - Subdural Hemorrhage present on admission."

12/02/21 [Falls Care Plan] documented, Problem- Falls. Further review of the care plan revealed multiple interventions including continue hourly check on residents.

12/02/21- 12/ 27/21- Review of nursing progress notes, medication administration records, and treatment administration records lacked documented evidence staff monitored Resident #1 hourly as outlined in the care plan. (It should be noted that the resident was transferred to the hospital on 12/27/22 and did not return to the facility).

During a face-to-face interview on 10/31/22 starting a 12:20 PM, Employee #2 (DON) stated that if the resident was monitored hourly it would be documented in the nursing progress notes, medication administration record, or treatment administration record.

Please cross reference (483.25 Quality of Care F689)

2. The facility' staff failed to apply cold compresses to Resident #6's right eye as ordered.
Resident #6 was admitted to the facility on 06/12/18 with multiple diagnoses including

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F 684	Continued From page 18	F 684		

dementia, restlessness, agitation, and edema.

Review of a District of Columbia Intake form dated 02/07/22 documented, "Resident has a new that was identified this am ...dark blue discoloration with soft tissue swelling under right eye ..."

Review of the resident's medical record showed the following:

01/25/22 [Significant Change Minimum Data Set] documented, Under Section C (Cognitive) the resident did not have Brief Interview for Mental Status summary score, indicating the resident was not able to take the test. Under Section E (Behavior) the resident was coded for rejection of care one to three times a week. Under Section G (Functional Status) the resident was coded for requiring extensive assistance from one staff member for bed mobility, and Under Section M (skin Condition) the resident was not coded for skin problems and using a pressure reducing device for bed.

02/04/22 at 12:12 PM [Nursing Progress Note] documented, " ...Resident has a new issue that were identified this am ... dark blue discoloration with soft tissue swelling under the right eye ...5cm (centimeters) X 3.5 cm. Resident unable to explain how she obtained the discoloration due to her advanced dementia ...NP (nurse practitioner) ordered cold compresses application for two days ..."

02/04/22 [Physician Progress Note] documented, "Staff requested pt. (patient) be evaluated for under right eye swelling ...assessment/plan right

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F 684	Continued From page 19 facial swelling, monitor for now can apply ice/cold compress to right facial area BID (two-times-a day) until resolved. Review of Resident #6's medication and treatment administration record from 02/04/22 to 02/06/22 showed that resident did not receive the prescribed treatment for cold compress four times as ordered. Instead, she received the cold compress two times. During a face-to-face interview on 11/03/22 at approximately 3:00 PM, Employee #2 (Director of Nursing) stated that she did not see in Resident #6's record where the resident received cold compresses twice a day ordered.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 19 sampled residents, the facility's staff	F 686		

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F 686	Continued From page 20 failed to provide care consistent with professional standards of practice to promote healing of Resident #2's Moisture Associated Skin Disorder (MASD). Subsequently, Resident #2's sacrum MASD declined to a Stage III pressure ulcer/injury. These failures resulted in actual harm to Resident #2 when it was determined that the resident's Moisture Associated Skin Disorder to the sacrum, first observed on (04/20/2022) was not treated in accordance with the Nurse Practitioners recommendation. Seven days later, the skin disorder further declined, and the resident was observed with a Stage III pressure ulcer/injury to the sacrum. The findings included: Resident #2 was admitted to the facility on 01/28/17 with multiple diagnoses including Cerebral Vascular Accident, Hemiplegia affecting Left Side, Generalized Weakness, and Diabetes Mellitus. Review of District of Columbia Department of Health's Intake Information form dated 07/07/22 documented, "[Resident's name]... [had an] infected bedsore... the nurses there neglected to their job, the bedsore was not being treated properly..." Review of the resident's medical record showed the following: 12/08/21 {Phuysican order] directed, "Cleanse sacrum with soap and water, pat dry, apply A&D ointment TID (three-times-a-day) for protection".	F 686	**I. Corrective action for residents noted to have been affected by the deficient practice.** Resident # 2 was discharged on 6/4/2022. **II. How will the facility identify other residents having the potential to be affected by the same deficient practice?** Current residents with skin conditions will be assessed by the licensed nurse on or before 1/26/2023 to review current treatment to promote healing for pressure ulcers. 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 re-educated the licensed nurses on skin identification, evaluation and monitoring, as well as implementation of ordered treatments on or before 1/26/2023. Residents with new skin integrity issues will be reviewed for the implementation of ordered treatments by the Interdisciplinary Team during the daily clinical meeting for skin interventions and treatment. During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with new skin conditions for skin evaluation, interventions and treatment. The review will be documented in the Resident's clinical record. The Unit Manager or designee	1/26/23 1/26/23 1/26/23

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F 686	Continued From page 21 02/15/22 [Significant Change Minimum Data Set] showed the following: Section C (Brief Interview for Mental Status Summary Score) documented the resident had a score of 9 indicating that the resident had moderately impaired cognition. Section E (Behavior) did not code the resident for rejection of care. Section G (Functional Status) coded the resident as requiring extensive assistance from two (2) staff members for bed mobility, being totally dependent on two staff members for toilet use, being totally dependent on staff for bathing, and using a wheelchair as a mobility device. Section GG (Functional Abilities and Goals) coded the resident as always being incontinent of bowel and bladder and not being on a toileting program. And Section M (Skin Conditions) coded the resident for being at risk for developing pressure ulcers and injuries but did not have any at the time of assessment. 04/07/22 [Braden Scale for Predicting Pressure Score Risk] documented the resident had a score of 10 indicating that Resident #2 was at risk for developing pressure ulcers/injuries. 04/07/22 to 04/20/22 [Treatment Administration Record] showed, the nursing staff was providing care per the following order [start date of 12/08/21], "Cleanse sacrum with soap and water, pat dry, apply A&D ointment three-times-a-day (6 AM, 2 PM, and 10 PM). 04/20/22 at 12:07 PM [Skin Evaluation] form assessed by Employee #16 (License Practical Nurse/LPN) showed, " ... sacrum MASD (Moisture Associated Skin Damage) ... size - length 2.5 centimeters and width 2.5 centimeters ... description - slough not applicable, 100% pink granulating tissue, no drainage, no cellulitis, no	F 686	F686 (continued) will randomly review wound evaluation forms for 3 months for treatment that promotes healing. Findings from the review will be corrected by the Unit 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 audit 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:** 1/26/2023	1/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 22 foul smell, ...Treatment - Z guard cream plus [and] A&D ointment three-times-a-day and as needed ... Nurses Notes: Resident was observed with opening on sacrum during ADL (activities of daily living) care by assigned CNA (certified Nurse Aide) ...Resident denies pain on assessment. NP (Nurse Practitioner made aware, new order received for Z guard plus [and] A&D ointment tid and prn ..." (Zguard is indicated to protect minor skin irritation associated with diaper rash and to help seal out wetness. Also protects and helps relieve chapped or cracked skin. https://www.woundsource.com/product/remedy-phytoplex-z-guard-skin-protectant-paste) Review of the physician's orders and the TAR from 04/20/22 to 04/26/22 lacked documented evidence that Z guard cream plus was ordered to treat the resident's MASD. 04/20/22 to 04/26/22 [Treatment Administration Record] showed, the nursing staff was providing care per the following order [start date of 12/08/21], "Cleanse sacrum with soap and water, pat dry, apply A&D ointment three-times-a-day (6 AM, 2 PM, and 10 PM)". However, there was not documented evidence that nursing staff applied Z-guard. 04/26/22 at 9:00 AM [Physician Progress Note]-eating 25-50 %...no skin breakdown ...left sided weakness and contracted ... It should be noted, that the physician's note of 04/26/22 at 9:00 AM records that the resident has no skin breakdown, however the resident was noted with MASD to her sacrum on 04/20/22.	F 686		

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F 686	Continued From page 23 04/27/22 at 12:31 PM [Nursing Progress Note] documented - Sacrum Stage 3 measured 4X2 centimeters (length), 4X8 centimeters (width), 40% slough, pink granulating 60%, no cellulitis, mild serous drainage. New order received for Sal Na cream plus Santyl ointment two-times-a-day and as needed cover with Allevyn Life (foam dressing), [resident representative name] made aware ... 04/27/22 at 20:40 (8:40 PM) [Physician Consult Record] documented, "Report- Sacrum Stage 3, 4.2 X 4.8 cm (centimeters), slough 40 %, pink granulation 60 %, mild serious drainage) cellulites. Recommendations - Salna +Santyl bid (two-times-a-day) and prn (as needed), cover with bordered dressing." 04/27/22 at 22:00 (10:00 PM) [Physician Order] directed, "Cleanse sacrum wound with normal saline, pat dry, apply Sarna cream and Santyl), cover with Allevyn life, twice a day [and] as needed ..." There was no evidence that facility staff provided the treatment as prescribed by the NP recorded in the "Skin Evaluation form" dated 04/20/2022. Review of Resident #2's care plan dated 08/30/21 revealed the following: Problem - Pressure Ulcer/Skin Prevention) documented [resident's name] is at risk for pressure injury secondary to her decreased mobility, incont [incontinence] and inability to toilet herself. Goal - [resident's name] will maintain skin integrity without new skin related injures over the	F 686		

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F 686	Continued From page 24 next review period. The care plan outlined multiple interventions including observe skin for redness and breakdown during routine care, and [provide] treatment as ordered when needed ... During a face-to-face interview on 11/07/22 at approximately 9:00 AM, the resident's physician stated that she was not aware that Resident #2 had MASD wound. However, she was informed by the nursing staff that the resident had a Stage III sacral wound on 04/27/22 at which time she assessed and gave treatment orders. During a face-to-face interview on 11/08/22 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated she did not see where the staff had provided the treatment for Z guard. There was no evidence that facility staff implemented the comprehensive care plan intervention, "[provide] treatment as ordered when needed ..." when they failed to transcribe the physician's order to apply Z guard to Resident #2's sacrum MASD when it was first identified on 04/20/2022. Subsequently, within seven days (04/27/22), Resident #2's sacrum MASD declined to a Stage III pressure ulcer/injury.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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	095034	A. BUILDING _____ B. WING _____	C 11/16/2022

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F 689	Continued From page 25 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, that record reviews and interviews, for four (4) of 19 sampled residents, the facility's staff failed to ensure that Resident #1 received adequate supervision to prevent a fall with injury (subdural hematoma) on 11/18/21. Subsequently, following the fall, the resident required surgery repair (left decompressive hemi-craniotomy for evaluation of subdural hematoma). Failed to ensure that: Resident #3 received adequate supervision to prevent an elopement on 03/10/22; Resident #4 was secure in mechanical lift during a transfer which led to the resident having an assisted fall with minor injury (pain) on 06/22/22; and Resident #5 was not secured in bed which led to fall without injury on 09/30/22. (Residents' #1, #3, #4 and #5) These failures resulted in actual harm to Resident #1 The findings included: 1. The facility's staff failed to ensure Resident #1 received adequate supervision to prevent a fall with injury (subdural hematoma) on 11/18/21. Subsequently, following the fall, the resident required surgery repair (left decompressive hemi-craniotomy for evaluation of subdural hematoma). Resident #1 was admitted to the facility on 05/13/21. The resident had a history of multiple diagnoses including history of falls, muscle weakness, generalized osteoarthritis, age-related debility, hypertension and epilepsy.	F 689	F689 **I.Corrective action for residents noted to have been affected by the deficient practice.** A) Resident #1 was discharged on 12-25-2021 B) Resident #3's wanderguard was replaced on 3/9/2022. The access code for the memory care door was also changed on 3/9/2022. C) Resident #4 has had no further incidence of concern regarding transfers. D) Resident #5 Care plan was updated on 1/3/2022 to include non-compliance with maintaining her bed in the lowest position. Resident #5's bed enabler was checked on 12/30/2022 and is functioning. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Unit Manager or designee will review the current resident care plans for fall interventions on or before 1/26/2023. The unit manager or designee also reviewed current residents, who are at risk for elopement. There are no residents who require 1:1 supervision. **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.**	1/26/23 1/26/23 1/26/23

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F 689	Continued From page 26 Review of Resident #1's medical history prior to admission to the facility revealed a computed tomography scan (CT scan of the resident's head) which showed no cranial abnormalities. A review of the District of Columbia's complaint intake #DC00010417 documented, Did the [resident] suffer any physical injuries? Yes, brain clot surgery [local hospital's name] 11/19/21 ... Complaint: 09/18/21- first fall ...explanation of injury didn't match what I expected when I saw him [Resident #1] in a video chat. 10/23/21- he [Resident #1] fell again not going to hospital ...11/18/21 he fell again doctor wants him to go to the hospital ...admitted and had surgery [left decompressive hemi-craniotomy] on 11/19/21 ...three falls are two too many should have had a better safety plan for patients [residents]. He came their [there] with a history of fall from 1/2021 ...not sure how many other times he fell not witnessed [brain blood] clot is [was] older and during the time he was in the nursing home." Review of the policy tilted, Fall Policy with a last approval date of 01/2022 instructed staff complete the Hendrich II Fall Risk (or similar fall risk evaluation) during admission and quarterly ... Review of medical record showed the following: 05/13/21 - The record lacked documented evidence the facility's staff completed a Henrich II Fall Risk (or similar fall risk evaluation) during the resident's admission. 08/10/21- [Quarterly Minimum Data Set]	documented, under Section C (Cognitive Pattern) Resident #1 had a Brief Interview for Mental	F 689	F689 (Continued) The staff education nurse or designee will re-educate and observe the current nursing staff on utilizing the mechanical lift safely and fall prevention. The social workers will be re-educated on discharge planning for residents who require 1:1 or before 1/26/2023. The staff education nurse or designee re-educated current staff on elopement and reporting

maintenance needs to facilities maintenance on or before 1/26/2023. During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with new or changed fall or elopement risk for safety interventions. The review will be documented in the Resident's clinical record. The unit manager or designee will complete

random

observati

ons for wander guard placement, mechanical lift transfers,placement of bed enablers and fall interventions weekly for 3 months. Findings from the review will be corrected immediately by the Unit manger or designee.

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

1/26/23

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F 689	Continued From page 27 Status summary score of "9", which suggested that the resident had a moderately impaired cognitive status. Under section E (Behavior)- the resident was not coded for rejection of care. Under section G (Functional Status) the resident was coded for needing extensive physical assistance from one staff person for transfers between surfaces and toilet use, the resident required supervision from one staff member for walking in his room. And used an assistive device (walker) for mobility. Under Section J (Health Condition) the resident was coded for not having any fall since admission. Under Section O, the resident was not coded for receiving physical or occupational therapy services, And Under Section P (Restraints and Alarms) the resident was not coded for using any restraints or alarms. 08/01/21 to 08/31/21- the record lacked documented evidence the facility's staff completed a quarterly Hendrich II Fall Risk (or similar fall risk evaluation). Review of Resident #1's care plans showed the following: Care Plan Problem: [Resident #1's name] requires assistance with related to pain, dementia, and depression with an initial date of 09/02/21. Continue review of the care plan revealed multiple interventions including need extensive assistance with transfers, keep environment clean, clutter free and provide adequate light, keep personal items within reach, complete fall risk quarterly and as indicated. Care Plan Problem -Falls with an initial date of 09/03/21. Interventions included physical and occupational therapy consult as needed	F 689	F 689 (Continued) Monitoring is indicated . **V.Completion: 1/26/2023**	1/26/2023

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F 689	Continued From page 28 09/18/21 at 4:46 PM [Nursing Progress Note (1st documented fall)] documented, "at about 4:30 PM resident was observed on the floor in a supine position in the hallway in front of his room with his walker close by. Resident was observed walking in the hallway towards his room then tripped and fell. Resident stated that he went to get a blanket...tripled [tripped] on his walker and fell. Sustained skin tear to right upper eyelid, swollen measured 3 cm (centimeter) X 0.6 (cm) with minimal bleeding, pressure and ice applied. Resident complained of pain on right eye lid. Dr notified ...transfer to ER (emergency room) for further evaluation and treatment ..." Review of the Hendrich II showed that on 09/18/21 at 5:37 PM the resident had a score of "7" indicating he was a high risk for having falls. 09/19/21 at 10:49 AM [Hospital Discharge Summary] documented, reason for visit- fall and head injury. Diagnoses - multiple closed fractures of facial bone, subdural hematoma, facial hematoma, and facial laceration ...you have been seen for a subdural hematoma. On your CT scan it does not look recent and was not caused by today's fall. It was probably from another fall or minor injury at some point in the last few weeks or months ... 09/19/21 at 1:55 PM [Nursing Progress Note] documented, resident returned to the facility at 12:00 noon from [local hospital's name] where he was transferred after being observed on the floor ...He is alert and verbally responsive ...has periods of confusion ...steri-strips noted to the lateral area of right brow with no active bleeding, no swelling, no bone protrusion. Discoloration	F 689		

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F 689	Continued From page 29 also noted especially around the right eye and right lower eyelid area ... 09/19/21 [Hospital After Visit Summary] documented, "Reason for visit- fall and head injury. Diagnoses - multiple closed fractures of facial bone, subdural hematoma, facial hematoma, and facial laceration ...you have been seen for a subdural hematoma. On your CT scan it does not look recent and was not caused by today's fall. It was probably from another fall or minor injury at some point in the last few weeks or months ..." 10/23/21 at 10:41 PM [nursing progress note (2nd documented fall)]- at 10:20 PM writer was called by assigned CNA (certified nursing assistant) to report an unwitnessed fall, upon arrival to residents room, resident was found in a sitting position by his chair in his room, when asked what happened stated, "I was trying to get up" [but] didn't give any other information ...head to toe assessment done ...no acute distress ...initiated neuro-checks ...alert but oriented X1 ...educated to always call for assistance and verbalized understanding ... Care Plan Problem- Falls with an initial date of 10/23/21. Interventions included physical/occupational therapy screen post fall, resident will be queuing to always call for help before any transfer and keep room clutter free, dry floor, and low bed. 11/02/21 [Quarterly Minimum Data Set] documented, under Section C (Cognitive Pattern) Resident #1 had a Brief Interview for Mental Status summary score of "4", which suggested	F 689		

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F 689	Continued From page 30	F 689		

that the resident had a severely impaired cognitive status. Under section E (Behavior)- the resident was coded for rejection of care behavior that occurred 1 to 3 days a week. Under section G (Functional Status) the resident was coded for needing extensive physical assistance from one staff person for transfers between surfaces and toilet use, the resident required supervision from one staff member for walking in his room. And used an assistive device (walker) for mobility. Under Section J (Health Condition) the resident was coded for having one (1) fall with no injury since his admission. Under Section 0 the resident was the resident was coded for receiving occupational therapy services. And, Under Section P (Restraints and Alarms) the resident was not coded for using any restraints or alarms.

It should be noted that Section J of the MDS dated 11/02/21 is inaccurately coded under section J as the resident had two falls within this look back period.

11/17/22 at 11:50 PM [Professional Communication Form (3rd documented fall)] documented, " ...fall ...resident hit his head ... temperature 97.1, pulse 56, respirations 20, blood pressure 108/62, pulse ox 98% on room air ...resident was more confused, change in behavior, insomnia ...transfer to hospital ...

11/18/21 at 3:08 AM [Nursing Note] documented, " ...at 11:50 PM CNA (certified nursing assistant) called to this write's attention and reported resident was observed on the floor ...resident was lying on the floor near his bed, [resident's] head was very closed (sp) to the dresser, on assessment noted on the top of his head skin was scrapped, resident was aert [alert] and

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F 689	Continued From page 31	F 689		

verbally responsive, [Resident #1] stated [he was] trying to get his socks.

11/18/21 at 5:41 AM [Supervisor Nursing Note] documented," called received for 2nd Floor charge nurse at 11:50 PM that resident was observed lying on the floor close to dresser at the foot of the bed ...upon arrival, resident observed in bed resting, with abrasion measured 1 cm (centimeter) X 2 cm not at top of his head ...resident stated "I was trying to get my socks from the dresser ...for work ...then I fell , bending down ...and hit my head on the dresser ...head to toe assessment completed ...resident denied pain. Neurological assessment implemented and no changes from resident baseline ...

Care plan Problem- Fall with an initial date of 11/18/21. Interventions included transfer resident to ED (emergency department) for further evaluation, monitor sleep pattern X 1 week, anti-roll back wheelchair for safety when out of bed, and corner guard applied to edges of furniture in resident's room.

11/20/21 at 1:39 PM [Nursing Progress Note] documented, " ... the ER (emergency room) nurse informed writer that resident was admitted [to] ...medical surgical ICU (intensive care unit) on 11/18/21, and ICU nurse informed writer that there was no discharge plan for resident yet."

12/02/21 at 7:59 PM [Nursing Progress Note] documented, "resident ...re-admitted to facility at about 2:30 PM from [local hospital's name] after being treated for subdural hematoma evacuation after a fall ...he is alert, awake, oriented to self

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F 689	Continued From page 32 ...resident was re-admitted to the unit with diagnoses of subdural hemorrhage ...left side of head surgical site sutures intact, dry and healing progresses well ..." 12/02/21 [Hospital Discharge Summary]-"CT head shows bilateral subdural hematomas. Pt taken to the operating room for left decompressive hemi-craniotomy for evacuation of subdural hematoma. 11/19/21- admitted to surgical intensive care unit status-post fall with bilateral SDH (subdural hematoma) L > R with left to right shift. Radiology review details shows ...Bilateral subdural hematoma (subacute/chronic with questionable acute superimposed subarachnoid hemorrhage versus artifact ...There is a mild rightward midline shift ...Discharge Diagnosis - Subdural Hemorrhage present on admission." A review of rehabilitation notes showed an occupational therapist progress and discharge summary note dated 11/23/2021, documented, the resident started care from 09/21/21 to 11/18/22 ...Indoor mobility (ambulation) -resident needed partial assistance of another person to complete activities ...functional transfer from sit to stand [the resident required] stand by assist (close enough to reach patient if assistance needed) ...precautious -falls ...patient was unexpectantly discharged to hospital. The complainant stated during a telephone interview on 10/25/22 at approximately 2:30 PM, "The staff took insufficient care of my dad (Resident #1)." The complaint stated that the resident fell for the first time on 09/18/21.	F 689		

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F 689	Continued From page 33	F 689		

According to the complainant, the staff kept giving her conflicting explanations about the (09/18/21) fall because her dad didn't look like what the nurses described. She said that Resident #1 looked horrible, with a black and blue face, a fractured nose, and an eye fracture. Also, the staff called her an informed that Resident #1 suffered a second fall on 10/23/21, but he did not require a hospital transfer. The complainant also said, Her father had to have an operation to remove a brain blood clot after his third fall on 11/18/22."

During a face-to-face interview on 10/28/22 starting at 2:31 PM, Employee #3 (Rehab Director) stated that staff should have provided stand by assist (been no more than an arm length away from resident for safety). When asked, if staff should have been at least an arm length away from Resident #1 with the fall on 10/23/22, Employee #3 stated, "yes". Additionally, the employee said that according to the therapy notes Resident #1 was not safe to ambulate independently in his room on 11/18/21. He required the assistance from another person to complete the activity. When asked, how is nursing staff made aware of the recommendation for rehab, Employee #3 stated they are discussed weekly during utilization review meetings. The employee was asked for copies of the utilization review notes at the time of the interview; however, the notes were not provided to the surveyor for review.

During a face-to-face interview on 10/29/22 at 5:00 PM, Employee #4 (Occupational Therapist) was asked how was nursing staff made aware that the resident required stand-by-assistance with transfers and assistance from staff with

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F 689	Continued From page 34	F 689		

ambulation? The employee said that he made nursing staff aware of the assistance the resident required during a care plan meeting on 09/23/21. Employee #4 also stated that Resident #1 was impulsive.

During a telephone interview on 10/31/22 starting at 12:14 PM, the resident's physician stated that Resident #1's daughter brought the resident to the nursing home because he was falling at home. According to the physician, the resident failed to call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help. When we have patients with dementia, they may refuse care (call for assistance from staff). I asked nursing staff for one-to-one care for him [Resident #1], but they told me that they don't have one-to-one services. Additionally, the physician, stated that he could not remember what nurse he talked to about one-to-one services for the resident.

During a face-to-face interview on 10/31/22 starting a 12:20 PM, Employee #2 (DON) who was present doing the telephone interview with the previously mentioned telephone interview with the resident physician, said that the physician was right when he said the facility does not offer one-to-one services for residents. The employee was then asked how did you keep Resident #1 safe from falls? The employee said we moved him closer to the nursing station. The employee was then asked how was that an arm length away as recommended by rehab. The employee failed to provide an answer.

2. The facility staff failed ensure Resident #3 received adequate supervision Subsequently, the

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F 689	Continued From page 35	F 689		

resident eloped from the facility on 03/10/22.

Resident #3 was admitted to the facility on 04/29/21 with multiple diagnoses including Alzheimer's Disease and Dementia.

Review of a District of Columbia Intake form #DC00010619 documented, " ...the resident was missing from the unit at 5:15 PM ...Another staff from the activity department brought the resident to the unit at 5:30 PM ...the resident [was] on 12th Allison Street NE (at the entrance of the campus of the facility). Resident was assessed ...no skin bruises, discomfort, distress ...She thought she could walk outside to get some fresh air on her own ...

During an observation on 11/03/22 at approximately 10:00AM, Resident #3 was walking around the talking and laughing with other residents. The resident had on a wander/elopement alarm (bracelet) on her ankle. She was oriented to her name only and unable to recall the incident when she wandered away from the facility on 03/09/2022. Further observation showed the unit was secured (locked) with monitors and alarms to capture people entering and exiting the unit.

Review of the resident's medical record showed the following:

07/15/21 [Physician Order]- "Roam alert for safety monitoring- check placement every shift ..."

01/31/22 [Quarterly Minimum Data Set] showed Under Section C (Cognitive Pattern) the resident a Brief Interview of Mental Status summary of "3" indicating the resident was severely impaired

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F 689	Continued From page 36	F 689		

cognitively. Under Section E (Behavior)- the resident was not coded for refusal behavior. Under Section G (Functional Status)- the resident was coded for activity did not occur for locomotion off the unit, needing supervision of one staff member when walking in the corridor, and needing set-up for walking in her room. Under Section O- the resident was not coded for receiving psychological therapy. Under Section P (Alarms) the resident was coded for using a wander/elopement alarm daily.

03/01/22 to 03/09/22 [Medication Administration Record] showed that nursing staff was checking the placement of the wander/elopement alarm every shift.

03/09/22 at 10:26 PM [Nursing Progress Note] documented, "At 4:30 PM this writer noted resident was in her room alert and verbally responsive with her room alert on her right wrist but non-compliant in keeping it on. At 5PM this writer notice resident was not in her room ...We searched for the resident ...within the unit. While searching ...activity personnel show up with resident. She reported that the resident on 12th and Allison Street ...On assessment [resident] is calm, no distress noted ...and without her room alert (wander/elopement device). A new room alert was immediately place on resident and its working properly ..."

03/09/22 [5 Working Day/Final Report] documented, " ...Summary of Investigation; Ms. Brown left the memory care unit, when a visitor held the door open for her. The following actions are in place to prevent further exits: Notice was sent to RR (resident representative), unit access and exit changed, and staff was re-educated on

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F 689	Continued From page 37	F 689		

the elopement prevention process.

03/10/22 at 7:45 AM [Physician Progress Note] documented, "Resident was found by staff member outside the building on the street, left outside the unit with some other family member ....no injuries noted ...PT (patient) to keep roam alert (wander/elopement alarm).

03/15/22 at 4:01 PM [Social Work Progress Note] documented, "A care plan meeting was held 3/14/22 to address [resident's name] elopement on 03/09/22. In attendance virtually ...[two family members names]. How [resident's name] managed to get off the unit was explained: she was unintentionally let out of the unit at 5:13 PM by another resident's family member, she was returned to the unit by staff at 5:27 PM. Family ...watched the security footage (video) of the elopement ...In order to prevent any future risk of elopement, the security code for the floor has ben changed and will not be disturbed to family or visitors. All visitors to the unit will need to be escorted onto and off the unit by staff ...[resident's name] is also wearing a roam alert bracelet.

Review of the resident's care plan showed the following:

08/14/21 - "Problem- [Resident's name] is at risk for ...elopement. Intervention included follow community elopement evaluation and monitoring process ..."

10/01/21 - "Problem - Potential for elopement from the facility secondary to dx (diagnosis of dementia/verbalized intentions to leave the facility. Interventions included apply roam mate bracelet as ordered, access ...for potential to

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F 689	Continued From page 38 wander, replace roam alert if becomes lost, orient to surroundings ..." 01/07/22 -"Problem [Resident's name] has impaired behavior related to exit seeking, hovering around the exit doors (with a start dated on ...Interventions included nursing to re-direct resident when standing at the exit door ..." During a face-to-face interview on 11/03/22 at approximately 3:00 PM, Employee #5 (Activity Assistant) stated that when she was going home for the day, she saw Resident #3 at the back of the hospital (located on the same grounds as the nursing home). She escorted the resident back to the nursing home. During a face-to-face interview on 11/03/22 at approximately 4:30 PM, Employee #1 (Administrator) stated that they looked at the security video and saw that that another resident's family member let Resident #3 out of the unit. When asked, if the alarm went off when resident went through the door, the employee stated no because she did not have her wander/elopement alarm on at the time. She removed the alarm. We put a care plan in place for removing her wander/elopement alarm. 3.The facility's staff failed to ensure Resident #4 was secure in a mechanical lift during transfer which led to the resident having an assisted fall with minor injury (pain). Review of District of Columbia Intake form #DC00010829 dated 06/22/22 documented, "	F 689		

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F 689	Continued From page 39 ...resident was transferred with a full body mechanical left [lift] to the bed to wheelchair with 2 staff ...in an attempt to adjust the mechanical pad left underneath her for comfort while in the wheelchair, suddenly resident slide off the wheelchair to the floor in a sitting position in front of her wheelchair ...she reported pain to left hip on touch and by nodding her head, no swelling noted, and skin warm and dry to touch. During an observation on 11/10/22 at 8:45 AM showed Resident #4 alert, non-verbal, totally dependent on staff for activities of daily living. When asked about the fall on 06/22/22, the resident hunched her shoulders indicating that she did not know about the fall. Review of the resident's medical record showed the following: Review of Resident #4's care plans showed the following: 08/19/21 - "Problem- [Resident's name] needs assistance with daily activities of daily living care. Interventions included ...need total assistance with mobility ...need one person staff support mobility ...use wheelchair device for mobility ... " 08/19/21 - "Problem- [Resident's name] has a potential for falls related to hx (history) of seizure activity. Interventions included assist with all transfers and mobility prn (as needed) 05/31/22 [Annual Minimum Data Set] showed the following: Under Section C (Cognitive) Brief Interview for Mental Status summary score of	F 689		

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F 689	Continued From page 40 "12" indicating the resident intact cognitively. Under Section G (Functional Status) the resident was coded for extensive assistance from one staff member for transferring between surfaces and uses a wheelchair for mobility. Under Section J (Health Condition) the resident was not coded for fall since her admission to the facility. Under Section O (Special Treatments, Procedures and Programs) the resident was not coded for receiving occupational/physical therapy services. 06/22/22 at 1:09 PM [Nursing Progress Note] documented, "Nurse was called to the hallway by resident's assigned CNA (certified nursing assistant) at 11:30 AM ...resident was observed sitting on the floor in front of her wheelchair with legs stretched out ...about ...1:00 PM ...resident identified that she is feeling pain now on her left hip. Tylenol 500 mg (milligrams) po (by mouth) was given for pain. Order received for x-ray of left hip ..." 06/22/22 [Physician Order]- "X-ray of left hip for pain post fall." 06/23/22 [Physician Progress Note] documented, " Transferred from bed to chair with [name of mechanical lift] but slid and fell to floor ... left hip WNL (within normal limits)... Some pain with adduction ... Xray of (left) hip negative. Lower back pain on exam. Assessment/plan- status post fall, LT (left) lower back pain, ice TID (three-times-a-day), Naprosyn 500 mg (milligrams) BID (two-times-a-day) for 10 days. X-ray of lower back." 06/23/22- [X-Ray Results of Lumbar Spine]	F 689		

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F 689	Continued From page 41 documented, "Vertebral bodies are normal ...Impressions; mild-to-moderate degenerative changes in lumbar spine ..." Review of the facility's investigative notes showed the following: 06/22/22 [Incident Witness Statement Form] from assigned certified nursing assistant, documented, "We were transferring the incident [resident] in her wheelchair. While we were adjusting the pad to make her comfortable. She started sliding, so we lowered her to the floor in front of her wheelchair ..." During a face-to-face interview on 11/10/22 at approximately 1:00 PM, Employee #7 (Activity Assistant) stated, "Staff was trying to put the resident in her wheelchair. Because the blue sling (used with mechanical lift) was not under the resident properly, she (Resident #4) started to slide forward. When she started sliding forward, I helped the two staff members assist her down to the floor in front of her wheelchair." 4. The facility's staff failed to ensure Resident #5 was safe in bed which led to a fall without injury on 09/30/22. Resident #5 was admitted to the facility on 07/15/20 with multiple diagnoses including hemiplegia, muscle weakness, and need for assistance with personal care. Review of the District of Columbia's Intake Information form #DC00011009 documented, "	F 689		

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F 689	Continued From page 42 [At 8:00 AM ...Resident #5's name was observed lying on the floor beside her bed on her right side with both of her legs stretched out ...alert, oriented to name and place ...reported she rolled out of the bed to the floor and refused hitting her head...At 9:30 AM resident noted lethargic and difficult to arouse ...transferred to [local hospital's name] ..." An observation was conducted at 10:30 AM on 11/10/22 revealed Resident #5 was lying in bed, on her back and the bed was in high position (from the floor). The head of bed elevated at a 45-degree angle, and quarter side rails in up position. The resident was not eating at the time of the observation. Employee #13 (LPN/Licensed Practical Nurse) was called to the bedside. The employee lowered the bed and stated, "She is a fall risk and it's not safe to leave her bed elevated that high. The staff may have left the bed elevated when she was eating." Review of the resident's medical record showed the following: Review of the resident's care plan dated 11/27/21 showed the following: "Problem [Resident's name] fell ... Further review of the care plan revealed multiple interventions including place bed in lowest position while in bed ..." 09/20/22 [Quarterly Minimum Data Set] documented, Under Section C (Cognitive) the resident had a Brief Summary Score of "11" indicating the resident was intact cognitively. Under Section E (Behavior) the resident was not coded for rejection of care. Under Section G (Functional Status) the resident was coded for	F 689		

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F 689	Continued From page 43	F 689		

requiring extensive assistance from two or more staff members for bed mobility. Under Section J (Health Condition) the resident was coded for have one fall since admission. Under Section O (Special Treatment, Procedures, and Programs) the resident was coded for receiving occupational therapy services, and Under Section P (Restraints and Alarms) the resident was not coded for using physical restraints or alarms.

09/27/2022 [Hendrix II Fall Risk] documented that the resident has a score of "11" indicating that the resident was a high Risk for falls.

09/30/22 at 11:08 AM [Nursing Progress Note] documented, "At 8:00 AM ...[Resident #5] was observed lying on the floor beside her bed on her right side with both of her legs stretched out ...alert, oriented to name and place.... reported she rolled out of the bed to the floor and refused hitting her head. Denies pain or discomfort. Resident bed in low position.....assisted from the floor by 3 staff to bed via full body mechanical lift ... denies dizziness ..... no apparent injury noted ..... /s (vital signs) 117/74 (blood pressure), 78 (pulse), 20 (respirations), 97.5 (temperature) ... At 9:30 AM resident noted lethargic and difficult to arouse ... transferred to [local hospital's name].

09/30/22 at 8:08 PM [Nursing Progress Note] documented, "writer placed call to [local hospital's name]... nurse stated [Resident #5] was admitted ..."

09/30/22 [hospital discharge summary] documented, "Active problems principal urinary tract infection ... ED (emergency department) course ..... UA (urinary analysis) consistent with

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F 689	Continued From page 44 UTI (urinary tract infection), CT of the head no acute intracranial hemorrhage ...Hospital course-UTI confirmed ... in urine culture ... patient will complete course of (oral) antibiotics X 2 days ... Other medical issues are stable at this time ..." During a face-to-face interview on 11/10/22 at 12:10 PM, Employee #13 (LPN), who was the resident's assigned nurse on the day of the fall stated, "The resident was trying to reposition herself in the bed, and she rolled onto the floor on the left side of her bed. The bed was in low position. When ask was the resident's side rail up? The employee said, "The side rail was not attached to the bed. It was up against the wall. I don't if it was broken."	F 689		
F 812 SS=D	Cross reference DCMR 3211.1 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		

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F 812	Continued From page 45 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on an observation, staff interviews and record review, the facility's staff failed to store food in accordance with professional standards for food service safety, as evidence by a crawling insect observed crawling on ice chest where food was stored. The findings included: On 10/26/22 at approximately 12:00 PM, an observation of the facility's cafeteria used by residents, staff, and the public revealed a crawling on the perimeter of the ice chest where foods including salads, sandwiches, muffins and cheese was stored. After the surveyor made Employee #10 (Cashier) aware of the crawling insect, she used a paper towel to kill the crawling insect and wiped off the perimeter of the ice chest with a Oxivir TB wipe (disinfectant cleaner based on proprietary hydrogen peroxide effective cleaning performance. Disinfects in 60 seconds ... non-food contact sanitizer). https://www.diverseybrands.com/product/OxivirRTbOneStepDisinfectantCleanerandDeodorizingWipes6x7160ea12count Review of Pest Control Invoice showed the cafeteria treated with "pest control maintenance" on 10/19/22. During a face-to-face interview on 10/26/22 at	F 812	F812 **I.Corrective action for residents noted to have been affected by the deficient practice.** No residents were affected. Pest services was contacted and the canteen was treated and sanitized on 10/26/2022 **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Chef made rounds in the canteen and no additional pest sightings were observed on 10/26/2022. **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 Chef or designee re-educated the kitchen staff on process for contacting pest services; food safety and cleaning procedures. Pest Services will continue to make weekly visits. The Chef or Designee will randomly observe meal service 3 times per week times 3 months to ensure that food is served in a sanitary manner. Finding from the review will be corrected by the Unit Manager or designee immediately. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.**	1/26/23 1/26/23 1/26/23 1/26/23

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F 812	Continued From page 46 12:05 PM, Employee #11 (Chef) stated that should not have happened and he discarded the food from the ice chest and instructed staff to deep clean the ice chest. During a face-to-face interview on 10/26/22 at 3:58 PM, Employee #12 (Environmental Service Director) stated that they are contracted to have pest control maintenance weekly and when needed. The employee also said that the company had been contact and will be in today (10/26/22) to treat the cafeteria.	F 812	F812 (continued) Monthly review of completed audit results and trends will be completed by the Chef 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:** 1/26/2023	1/26/23
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		

	§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the		

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F 842	Continued From page 47 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842	F842 **I.Corrective action for residents noted to have been affected by the deficient practice.** A) Resident #2 was discharged on 6-4-2022 B) Resident #7's Hendrich II Fall Risk was completed on 12/1/2022. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** Current residents with skin conditions will be assessed by the licensed nurse on or before 1/26/2023. The licensed nurse will review the current resident Hendrich II Fall Risk assessments on or before 1/26/2023 for completion. **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 re-educated the current licensed nurses on skin identification, evaluation and monitoring and the completion of the Hendrich Fall Risk assessment following a fall. Resident's fall risk assessment will be reviewed for completion by the Interdisciplinary	1/26/23 1/26/23 1/26/23

	and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and		Team during the daily clinical meeting for completion. Residents with new skin integrity issues will be reviewed by the Interdisciplinary Team during the daily clinical meeting for skin interventions	

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F 842	Continued From page 48 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for two (2) of 19 sampled residents, the facility's staff failed to ensure: Resident #2's medical record contained accurate information related to Stage III pressure ulcer; And Resident #7's fall assessment dated 02/02/22 contained accurate information. The finding included: 1.Resident #2 was admitted to the facility on 01/28/17 with multiple diagnoses including Cerebral Vascular Accident, Hemiplegia affecting Left Side, Generalized Weakness, and Diabetes Mellitus. Review of the resident's medical record showed the following: 04/27/22 at 12:28 PM [Skin Evaluation Form] documented, Type- Moisture Associated Skin Damage ...Description-slough 40%, 60% pink granulating tissue, mild serous drainage, no cellulitis ... 04/27/22 at 12:31 PM [Nursing Progress Note] documented - Sacrum Stage 3 measured 4X2 centimeters (length), 4X8 centimeters (width), 40% slough, pink granulating 60%, no cellulitis, mild serous drainage. New order received for SalNa cream plus Santyl ointment two-times-a-day and as needed cover with Allevyn Life. [resident representative name] made aware ...	F 842	F842 (continued) and treatment. During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with new or changes in skin conditions, as well as residents with new falls, to include their assessments, interventions and treatment. The Unit Manager or designee will randomly review wound evaluation forms and Hendrich II Fall risk assessments weekly of residents for 3 months for accuracy. **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 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:** 1/26/2023	1/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 49 04/27/22 at 8:40 PM [Physician Consult Record] documented, Report- Sacrum Stage 3, 4.2 X 4.8 cm (centimeters), slough 40 %, pink granulation 60 %, mild serous drainage,) cellulites. Recommendations - Salna +Santyl bid (two-times-a-day) and prn (as needed), cover with bordered dressing. 04/28/22 at 11:16 AM [Skin Evaluation Form] documented, Type- Moisture Associated Skin Damage ...Description-slough 40%, 60% pink granulating tissue, mild serous drainage, no cellulitis ... During a face-to-face interview on 11/08/22 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated that the resident had a Stage III sacral wound not a MASD wound. The Skin Evaluation Forms dated 04/27/22 and 04/28/22 which documented the resident had a MASD wound were incorrect. 2.Resident #7 was admitted to the facility on 03/09/16 with multiple diagnoses including history of falling, difficulty walking, and muscle weakness. Review of the policy titled, "Falls," dated 01/22, showed that staff were to complete Henrich II Fall Risk (or similar fall risk evaluation) ...after every fall. On 11/08/22 at 11:25AM, observation showed Resident #7 sitting in a reclined geri-chair in the common area of the unit listening to music. When asked, what is your name? The resident just smiled.	F 842		

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F 842	Continued From page 50 Review of the resident's medical record showed the following: 12/14/21 [Quarterly Minimum Data Set] documented, Under Section C (Cognitive Pattern) the resident was coded for having problem with recalling memories to include after 5 minutes, long memories, current season, location of room, staff names/faces, and being in a nursing home. Also, the resident was coded for being severely impaired with daily decision making. And Under Section H (Bladder and Bowel) the resident coded for being always incontinent of urine and bowel. 02/02/22 [Nursing Progress Note] documented, "Resident noted to be lying on floor by housekeeping staff at 11:00 AM on 02/02/22 ...lying on her left side with feet stretched out and head resting on the floor bedside her bed ..." 02/02/22 [Hendrix II Fall Risk] documented that Resident #7 was oriented to person, place, and time. Also, the resident was continent of both bowel and bladder. During a face-to-face interview on 11/08/22 at 12:00 PM, Employee #9 (Licensed Practical Nurse) stated that she worked with the resident on the day of fall on 02/02/22. The employee also said that within the last year the resident was not oriented to time, place, or time and was incontinent of both bowel and bladder. During a face-to-face interview on 11/08/22 at 12:30 PM, Employee #8 (Unit Manager) stated that the Hendrix II Fall Risk dated 02/02/22 was inaccurate.	F 842		

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