

PRINTED: 05/12/2026  
FORM APPROVED  
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>090012</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/17/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR HILL REGIONAL MEDICAL CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1200 PECAN ST SE</b><br><b>WASHINGTON, DC 20032</b>                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| A 398                                                                         | Continued From page 1<br><br>conduct nursing assessments for three (3) out of six<br>(6) patients sampled receiving care in the facility.<br>(Patient #18, #19 and #20).<br><br>Findings include:<br><br>1. Review of the facility's policy "High Alert<br>Medications" revised 09/13/2024 showed "3.<br>Anticoagulants ...b) Are adhered to the<br>Anticoagulation policy- Safety and Monitoring<br>Protocols. c) IV [Intravenous] infusions are<br>independently double checked by two licensed<br>clinicians."<br><br>Review of the medical record showed Patient #28<br>presented to the Emergency Department with a<br>diagnosis of lower extremity graft occlusion.<br><br>According to physician orders anticoagulant Heparin<br>infusion was placed on 04/08/2026 at 8:12 PM.<br>Review of the Medication Administration Record<br>showed nursing staff administered Heparin infusion<br>at 8:41 PM, however documentation reflected<br>verification by only one nurse.<br><br>The surveyor conducted a face-to-face interview<br>with Employee #46, Registered Nurse, on<br>04/14/2026 at approximately 2:00 PM. According to<br>Employee #46, high alert medications such as<br>Heparin require verification by two nurses. The<br>employee further acknowledged missing<br>documentation, including a second nurse<br>verification for Patient #28.<br><br>2a. A review of the facility's patient assessment and<br>Re assessment According to ESI [Emergency<br>Severity Index] Level protocol, undated, revealed:<br>"ESI Level 3: Patient | A 398                                                                      |                                                                                                                          |  |                                                                    |

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| A 398                                                                         | Continued From page 2<br><br>Assessment (primary and focused) no less frequently than every two hours."<br><br>A review of Patient #18's medical record from 1/17/2026 revealed the patient presented to the ED (Emergency Department) at 4:48AM with chief complaints of abdominal cramping x [times] 1 [one] day and vaginal discharge. Patient #18 was triaged at 5:48 AM and assigned an ESI level 3 (three).<br><br>Further review of Patient #18's medical record revealed they were evaluated and discharged at 11:28 AM. There is no documentation of a nursing assessment conducted for Patient #18's Emergency Department visit.<br><br>2b. A review of Patient #19's medical record from 3/27/2026 revealed the patient presented to the ED (Emergency Department) on 3/27/2026 at 11:46AM with chief complaints "with concern for cough. Patient reports that [Patient #19] has had several days of productive cough for yellow mucus. Does report sore throat." The patient was triaged at 1:25 PM and assigned an ESI level 3 (three).<br><br>Further review of Patient #19's medical records revealed they were evaluated and discharged at 3:44 PM. There is no documentation of a nursing assessment conducted for Patient # 19's Emergency Department visit.<br><br>2c. A review of Patient #20's medical record from 4/5/2026 revealed the patient presented to the ED (Emergency Department) on 4/5/2026 at 12:12 PM with chief complaints of "cough, chest tightness, runny nose, and shortness of breath x [times] 1 week." The patient was triaged at 12:12 | A 398                                                                      |                                                                                                                          |  |                                                                    |

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| A 398                                                                         | Continued From page 3<br>PM and assigned an ESI level 3 (three).<br><br>Further review of Patient #20's medical records<br>revealed they were evaluated and discharged at<br>3:45 PM. There is no documentation of a nursing<br>assessment conducted for Patient # 20's<br>Emergency Department visit.<br><br>The Surveyor conducted a face-to-face interview<br>with Employee #35, the Nurse Manager Emergency<br>Department on 4/19/2026 at approximately 12:15<br>PM, and Employee #35 acknowledged that nursing<br>assessments were not conducted on Patients #18,<br>#19 and #20 while receiving care in the Emergency<br>Department. Employee #35 confirmed that nursing<br>assessments are to be done based on the patient's<br>ESI. | A 398                                                                      |                                                                                                                          |  |                                                                    |