Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0003	A. BUILDING: ______ B. WING ______	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE METHODIST HOME OF DC- FOREST HILLS	4901 CONNECTICUT AVENUE NW WASHINGTON, DC 20008

(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) COMPLETE DATE
R 000	Initial Comments	R 000		

Initial Comments

0000 Initial Comments
On 10/07/2022, the District of Columbia Department of Health ' s Intermediate Care Facilities Division received a complaint from a Social Worker at George Washington University Hospital (GWH) alleging that the Assisted Living Residence (ALR), was negligent in their provision of services and treatment to Resident #1. According to the complainant, the medical workups reported by the physician included concerns for neglect in the patient's care, noting the following allegations:

Allegation #1 - The resident had "large shoulder bruising."

Reviews of the resident's record failed to show documented evidence that the resident had bruising as a concern. However, during interview home health aide (HHA) #2, said that she observed "old bruises all over the resident's body. The primary care physicians (PCP) physical assessment showed the resident had "multiple skin discolorations to her lower extremities." According to the GWH's record, the resident's niece said the resident "bruises easily." During a telephone interview with the Resident #1's niece, she said that the resident bruised very easily and that she was not concerned about the bruises being a result of neglect. There was no evidence that the bruising was the result of abuse or neglect.

Conclusion: This allegation was not substantiated for neglect.

Allegation #2 - The resident was malnourished.

Findings: Review of weight documentation from

Provider's Plan of Correction:

Please start typing your responses here:

"This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Corretion is submitted to meet requirements established by State and Federal law; or Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of correction is prepared and submitted solely because of requirements under State and Federal laws.
The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, Director, Attorney or shareholder of the community or affiliated companies."

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R 000	Continued From page 1 07/08/2022 - 10/03/2022 revealed the residents weight fluctuated from 97 lbs. to 86 lbs. The resident weighed 88.6 lbs. on 10/03/2022. The ISP developed by the ALR did not address her weight or indicate an ideal body weight range for the resident. According to the nursing staff, the resident was evaluated by the dietician while at the skilled nursing facility. The skilled nursing services care plan showed a goal for the resident to maintain a weight of 86 lbs. +/- 3 lbs. The nurses indicated that the resident had always been very small and did not have any dietary restrictions. There were no concerns about her weight from a dietary perspective, however she was weighed before and after dialysis. During a telephone interview with the resident's niece, she said that her aunt was always a very tiny person. In the past, the physicians ordered dietary supplements for the resident to increase her weight, however the supplements did nothing to increase the resident's weight and was discontinued. The niece did not believe her aunt was malnourished and said she had a very good appetite. Conclusion: This allegation was not substantiated. Allegation #3 - The resident had deep wounds" (location not noted). Findings: See the information documented within this report Conclusion: This allegation was substantiated. Due to the nature of the complaint an onsite investigation was initiated on 10/11/2022, to determine the facility's compliance with the Assisted Living Law (DC Official Code §	R 000		

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R 000	Continued From page 2 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The findings and conclusions of this investigation were based on interviews with the assisted living nursing, and administrative staff, Personal Care Aides (PCAs), the administrative staff at Family and Nursing Care agency, and the podiatrists. Clinical and administrative records were also reviewed. Based on the findings of this investigation, it was determined that the allegation of neglect in the care of Resident #1 was partially substantiated and documented throughout this report.	R 000		
R 106	10110.1 Required Policies And Procedures 10110.1 An ALR shall develop and implement dated, written policies and procedures concerning its operation which shall be consistent with the Act, this chapter, and all other applicable District or federal law. Based on interviews and record reviews, the Assisted living residence failed to develop and implement policies and procedures to address 1), the timely receipt of assessment reports of consultants, 2), documenting the Primary Care Physician (PCP) and nursing review of the consultant's reports, 3), documenting if the PCP's agree or disagrees with the recommendations made by the consultant, 4), the timely reporting of changes in a resident's condition to the Unit Manager and 5), system for privately contracted personnel (Home Health Aides) to document care activities rendered, observed care rendered by others, and changes in client condition for one of one resident in the investigation (Resident #1). Findings included:	R 106		

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R 106	Continued From page 3	R 106		
	1. The facility failed to develop and implement policies and procedure to address the timely receipt of results of consultation assessments reports as evidenced below:		1.Upon discovery, the records of all residents who were being seen by the Podiatrist was reviewed to determine if any other resident was effected. No other residents were effected.	10/19/2022
	During an interview on 10/19/2022 at 3:12 PM, the NP was asked if she had seen the podiatrists' assessments prior to 10/05/2022. The NP said that she had not seen the assessments, nor had they been faxed to the PCP's office. She further stated that the podiatrist had not sent his note to the facility prior to 10/05/2022 and that she did not know anything about the wound prior to that day. No one voiced any concerns about the resident's feet. When asked if the consultants document their findings in the resident's record prior to their typed report being sent. The NP said consultants should put a note in the chart, however what they do is they see the patients, and then go home and type their notes. During the interview on 10/19/2022 at 2:08 PM, Podiatrist #2 was asked how long it took to get the report of his assessment to the facility. He said, "it takes five (5) days." During an interview on 10/24/2022 at 11:19 AM, the ALR's Director was asked if the facility had a policy to address the timeliness of receiving the outcomes of a consultant's assessment report. The Director said, there was no policy to address this issue.		2.The Facility immediately updated our policy and procedure to include that the Charge Nurses has the responsibility to review the consultation book daily and notify the PCP of any recommendations and document on the progress note the conversation with the PCP. 3. Charge Nurses have been in-serviced to review and notify the PCP of all recommendations by the consultant and document on the progress note. The clinical Manger will audit every month x 3, then every quarterly x 3 to ensure that the facility is in compliance with the new policy and procedure and send report to the DON every month. 4. The results of these audits will be reviewed in QAPI quarterly meeting.	10/19/2022 11/11/2022 Ongoing
	2. The facility failed to develop and implement policies and procedure to address when the PCP and nurses reviews a consultant's report as evidenced below:		1. Upon discovery, the records of all residents who were seen by the Podiatrist was reviewed to determine if other resident was affected. No other residents were affected.	10/19/2022
	Podiatrists #2 and #3 assessed resident #1 on 09/24/2022 and 09/29/2022 respectively. Review of the corresponding nursing progress notes and the Nurse Practitioner's (NP) notes did not show		2. The facility immediately updated our policy and procedure to include that the Charge Nurse reviews the consultation report upon receipt and notify the PCP. 3. Charge Nurses have been in-serviced to review and notify the PCP of all consults and document on the progress note.	10/19/2022 11/11/2022

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R 106	Continued From page 4 evidence that the nurses and NP acknowledged the Podiatrists evaluation and recommendations based on the assessment. The NP acknowledged that the consultants did not leave any notes. When asked if the consultants documented their findings in the resident's record prior to their typed report being sent to the facility, the NP said they should put a note in the chart, however what they do is they see the patients and go home and type their notes. During the interview on 10/19/2022 at 2:08 PM, Podiatrist #2 was asked how long it took to get the report of his assessment to the facility. The podiatrist said, "it takes five (5) days." During an interview on 10/24/2022 at 11:19 AM, the ALR's Director was asked if the ALR had a policy or procedure to address how the ALR knows when the PCP or NP reviews a consultant's reports. The director indicated that there were no procedures in place to address the issue.	R 106	The Clinical Manager will audit every month x3 then quarterly to ensure that the facility is in compliance with the new policy and procedure and send audit report to the DON every month. 4. The results of these audits will be reviewed in QAPI quarterly meeting.	Ongoing
	3. The facility failed to develop and implement policies and procedure to address documenting if the PCP's agreed or disagrees with the recommendations made by a consultant as evidenced below:		1. Upon discovery, the records of all the residents who were seen by the Podiatrist was reviewed to determine if any other resident was affected. No other residents were affected.	10/19/2022
	On 09/24/2022 Podiatrist #2 recommended that Resident #1 wear "larger toe boxed shoe-gear with mesh fabric to reduce friction and accommodate contracted digits." In addition, on 09/29/2022 Podiatrist #2 evaluated Resident #1 and recommended applying Silvadene 1% cream to the wounds on Resident #1's right foot. A review of Sept. 2022 nursing notes failed to show evidence that the nurses informed PCP about the podiatrist's recommendation. During interview with the ALR's Director on 10/24/2022, she was asked about the process for ensuring the PCP is made aware of a consultant's recommendations		2. The facility immediately updated our policy and procedure to include that the Charge Nurses has the responsibility to review the consultation report upon receipt and notify the PCP of the recommendations and document on the progress note.	10/19/2022
			3. Charge Nurses have been in-serviced to review and notify the PCP of all recommendations by the consultant and document on the progress note. The Clinical Manager will audit every month x 3 then quarterly to ensure that the facility is in compliance with the new policy and procedure and send the audit report to the DON every month.	11/11/2022
			4. The result of these audits will be reviewed in QAPI quarterly meeting.	Ongoing

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R 106	Continued From page 5	R 106		

and if there was a policy that outlined the process. The Director said the Charge Nurse will contact the PCP and inform him of the recommendations. The nurse is to document the conversation in the progress notes, and if the PCP agrees with the recommendation, he will write an order. The Director also said that the ALR had not developed a policy to address the issue.
At the time of the survey, the ALR failed to develop and implement policies and procedures to address timely receipt, review and disposition of consultant assessments and recommendations.

4. The ALR failed to develop and implement policies and procedures to ensure the Charge Nurses timely reported changes in a resident's condition to the Unit Manager as evidenced below:

During interview on 10/11/2022 at 10:31 AM, the Unit Manager [RN] said that on 10/03/2022, she received a picture of Resident #1's right foot from LPN #1. The next day she saw the dressing on the resident's foot. The manager said she checked the resident's chart and saw the orders for wound care. She then asked the Director of Nursing if the wound specialist could evaluate the resident's wound. When asked if she was aware of the wound prior to 10/03/2022, the manager said that was her first-time hearing or knowing about the wound.

On 10/17/2022 at 4:40 PM a review of the Charge Nurse position description showed no evidence that changes in a resident's condition or care should be reported to the Unit Manager.

It should be noted that the podiatrist wrote orders

Provider's Plan of Correction:

Corrective action	Complete date
1. Upon discovery, the records of all the residents who were seen by the Podiatrist was reviewed to determine if any other resident was affected. No other resident was affected.	10/11/2022
2. The facility immediately updated our policy and procedure to include that a change in condition must be completed whenever there is any alteration in skin integrity and will notify the Clinical Manager/Designee.	10/11/2022
3. The Nurses have been in-serviced on the process in notifying the Clinical Manager/ Designee in the change of condition. The Clinical Manager will audit all residents that have a change in condition for 3 months x 3, then quarterly and report to the DON.	11/11/2022
4. The result of these audits will be reviewed in QAPI quarterly meeting.	Ongoing

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R 106	Continued From page 6 for wound care on 09/29/2022. The RN was not made aware of the wound until 10/03/2022, four (4) days later.	R 106		
	5. The ALR failed to have a system for privately contracted personnel (Home Health Aides) to document care activities rendered, observed care rendered by others and changes in client conditions as evidenced below:		1. Upon discovery, the records of all the residents who have a privately contracted personnel was reviewed to determine if any other resident was affected. No other resident was affected.	10/14/2022
			2. The facility immediately updated our policy and procedure to include that residents with privately contracted personnel must report care activities and changes in conditions to the licensed nurse/ designee.	10/14/2022
	a. During an interview on 10/14/2022, Home Health Aides (HHA) #1 said that when she cared for Resident #1 on 09/19/2022 there were wounds on both of resident #1's legs/heels. When asked to describe the wounds, she said they were like skin tears. She said they were small areas "just a little bit open." When asked if she informed the nurses about the wounds, she said the wounds would come and then dry up. When they would come back, she would inform the nurse. When asked which nurse(s) she could not give a name. She also added that she was off for jury duty from 09/22/2022 to 09/23/2022, and when she returned to work on 09/26/2022, she saw a dressing on the resident's foot. On 09/28/2022 when they were preparing to go to dialysis "the nurse came to do the dressing. That is when I saw it was big." HHA #1 said she did not report the wounds to anyone because the facility was already caring for the wounds.		3. Privately contracted personnel have been in-serviced on reporting care activities and changes in condition to licensed nurse/designee. The Licensed Nurse/Designee shall report findings to the DON every month x3 months then quarterly.	11/30/2022
			4. The result of these audit will be reviewed in QAPI quarterly meeting.	Ongoing
	b. During interview on 10/14/2022, HHA #2 said that she cared for Resident #1 only one day on 10/04/2022. She noted that the resident's "skin was dark and had old bruises all over her body." She said when she took the resident to get her medications, a nurse asked her to take the resident's shoes off when she returned to her room. When the nurse came to check on the resident, she looked at the dressing and said, "oh			

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this is a new dressing" and instructed HHA #2 to put the resident's shoe back on. When asked if she reported the bruises to anyone, HHA #2 said she had not reported the bruises because they were old bruises.

c. During interview on 10/14/2022, HHA #3 said that on either 09/24/2022 or 09/25/2022 a doctor, possibly a foot doctor came to the resident's apartment and cleaned her feet and put a dressing on her heel. He asked for a pair of socks and put the socks on her feet and left the apartment. On 10/01/2022 the physician came saw the resident again. On 10/02/2022 the ALR's nurse took care of her foot. HHA #3 said she assisted the nurse by holding the resident's leg but did not see the wound.

During interview with the ALR Nurse Manager on 10/11/2022, she was asked about any instructions given to the HHA's regarding reporting changes in residents condition and the process of documenting care rendered the residents. The manager said she had instructed the HHA's to always report any changes in the resident's condition, however when asked for the documentation of those instructions the Nurse Manager said she did not document it.

Review of the HHA position descriptions on 10/11/2022 at 4:00 PM showed that the HHA was required to observe, record, and report the client's physical condition, behavior, and appearance. The HHA was also to keep a record of care given. On 10/13/2022 at 11:28 AM, interview with Administrators at the Home Health Agency revealed the there is a "spot on the mobile app for the HHA's to document any changes in the resident's condition." The agency's Director said that she "gets a notification

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R 106	Continued From page 8	R 106		

when the HHA reports something." She said on 09/19/2022 the HHA reported that the resident had a small wound and that the ALR was "tending to it." On 09/13/2022 the HHA reported that the resident had a visible wound on her right leg. The agency's DON said she spoke with the facility's RN who told her that "it had just happened and that the wound was small 2 inches, and that the ALR's nurses were aware and was caring for it.

There was no evidence that the ALR had developed systems to ensure HHA's provided documentation of observed wounds or wound care provided to the resident.

At the time of the survey, the ALR failed to develop and implement policies and procedures to address timely receipt, review and disposition of consultant assessments and recommendations.

The results of the ALR's failure to have the above policies and procedures in place to prevent neglect resulted in worsening of the condition of the resident's right heel wound and resulting in the resident being hospitalized. While in the hospital, the resident underwent a Doppler Study that showed the resident's superficial femoral artery was occluded. A wound assessment by the hospital's podiatrist and vascular surgeon revealed that the wound had exposed the heel's ligaments and bone. It was determined that the resident required an amputation of her right lower leg due to gangrene. Resident #1's family declined the surgical procedure and decided that the best course of action was to discontinue the resident's dialysis treatment and to place the resident under Hospice care. Resident #1 expired on 10/30/2022.

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R 000	Initial Comments	R 000		

On 10/07/2022, the District of Columbia Department of Health's Intermediate Care Facilities Division received a complaint from a Social Worker at George Washington University Hospital alleging that the Assisted Living Residence (ALR), was negligent in their provision of services and treatment to Resident #1. According to the complainant, the medical workups reported by physician included concerns for neglect in the patient's care, noting the following allegations:

Allegation #1 - The resident had "large shoulder bruising."

Review of the resident's record failed to show documented evidence that the resident had bruising as a concern. However, home health aide (HHA) #2, during interview said that she observed "old bruises all over the resident's body. The primary care physicians (PCP's) physical assessment showed the resident had "multiple skin discolorations to her lower extremities." According to the GWH's record, the resident's niece said the resident "bruises easily." During a telephone interview with Resident #1's niece, she said that the resident bruised very easily and that she was not concerned about the bruises being a result of neglect. There was no evidence that the bruising was the result of abuse or neglect.

Conclusion: This allegation was not substantiated for neglect.

Allegation #2 - The resident was malnourished.

Findings: Review of weight documentation from 07/08/2022 - 10/03/2022 revealed the residents weight fluctuated between 97 lbs. and 86 lbs. On

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R 000	Continued From page 1	R 000		

10/03/2022, the resident weighed 88.6 lbs. The ISP developed by the ALR did not address her weight or indicate an ideal body weight range for the resident. According to the nursing staff, the resident was evaluated by the dietician while at the skilled nursing facility. The skilled nursing services care plan showed a goal for the resident to maintain a weight of 86 lbs. +/- 3 lbs. The nurses indicated that the resident had always been very small and did not have any dietary restrictions. There were no concerns about her weight from a dietary perspective and was weighed before and after dialysis. During a telephone interview with the resident's niece, she said that her aunt was always a very tiny person. In the past, the physicians ordered dietary supplements for the resident to increase her weight, however the supplements did nothing to increase the resident's weight and was discontinued. The niece did not believe her aunt was malnourished and said she had a very good appetite.

Conclusion: This allegation was not substantiated.

Allegation #3 - The resident had deep wounds" (location not noted).

Findings: See the information documented within this report

Conclusion: This allegation was substantiated.

Due to the nature of the complaint an onsite investigation was initiated on 10/11/2022, to determine the facility's compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and

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R 000	Continued From page 2 Medicine) Chapter 101. The findings and conclusions of this investigation were based on interviews with the assisted living nursing, and administrative staff, Personal Care Aides (PCAs), the administrative staff at Family and Nursing Care agency, and the podiatrists. Clinical and administrative records were also reviewed. Based on the findings of this investigation, it was determined that the allegation of neglect in the care of Resident #1 was partially substantiated and documented throughout this report.	R 000		
R 201	Subheading Standard Of Care Sec. 501. Standard of care. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the nursing staff and consultants provided wound assessment and documentation within acceptable standards of care for one of one resident in the investigation (Resident #1). Findings included: A review of Resident #1's Physician's Orders (POs) on 10/11/2022 at 12:00 PM, showed that on 09/29/2022, Podiatrist #3 wrote an order for every-other-day wound care for Resident #1 and the Primary Care Physician signed the order on 10/01/2022. The next dressing charge should have been done on 10/01/2022, however review of the nursing notes failed to show evidence that the wound was assessed, and the dressing changed in accordance with the order. In a reviewed written statement dated 10/11/2022, LPN #2 wrote that "At about 7 PM on 10/01/2022 this writer went	R 201	1.Retrospectively, corrective action cannot be accomplished for the resident is no longer in Assisted Living. No other resident was affected by this practice. 2.Upon reassessment of residents there were no other residents identified with wounds. 3.Licensed Nurses and Podiatrist were in-serviced on acceptable assessment and documentation of wounds. The Clinical Manager/Designee audit for compliance monthly and report findings to the DON. 4. The result of these audit will be reviewed in QAPI quarterly meeting.	10/11/2022 10/17/2022 11/30/2022 Ongoing

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R 201	Continued From page 3 and did treatments on resident's right posterior heel. On assessment, wound was cleansed with NS (normal Saline), no drainage or odor noted or observed. wound was covered with scab. Silvadene 1% applied as ordered, covered with non-adherent pad and wrapped with Cling. Heel elevated on a pillow to float." There was no description of the length, width, or depth of the wound, and no description of the skin surrounding the wound. On 10/07/2022 DC Health received an allegation of neglect regarding the care of a wound to Resident #1's right foot. During a face-to-face interview on 10/11/2022 at 10:31 AM, the Nurse Manager said that on 10/03/2022 LPN #1 sent her a picture of a foot with a wound on it. She spoke with LPN #1 and inquired about the photo and was told that it was the wound on Resident #1's foot. The nurse manager said she did not know that the resident had a wound. On 10/04/202 the Nurse Manager requested that the resident's wound be evaluated by the wound specialist. At the time of the investigation, the Assisted Living Residence (ALR) failed to ensure the nursing staff and consultants provided wound assessment and documentation within acceptable standards of care for one of one resident in the investigation (Resident #1).	R 201		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities	R 292		

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R 292	Continued From page 4 and the health or safety of other residents. Based on interview and record review the Assisted Living Residence (ALR) failed to: (I) ensure its nurses conducted thorough physical assessments on admission, (II) ensure nurses and consulting physicians document care rendered to residents, (III) nurses and consulting physicians report changes in a resident's condition to the primary care physician (PCP), (IV) ensure nurses demonstrate knowledge on proper wound documentation, (V) develop a system to ensure consulting physicians documented findings of resident assessments and care rendered to residents in the resident's record on the day the of the assessment and (VI) include peripheral vascular disease (PVD), as identified by the Podiatrists, with the active diagnoses for one of one resident in the investigation (Resident #1). Findings included: I. The ALR's nursing staff failed to conduct thorough physical assessments on admission as evidenced below: On 09/15/2022, Resident #1 was re-admitted to the ALR from a skilled nursing facility. a), Review of the corresponding nursing note, written by licensed practical nurse (LPN) #1 showed that the nurse did not document that the resident had an AV fistula in her left arm, nor did the nurse assess the resident's peripheral pulses, or indicate that the skin on the resident's lower extremities were assessed. b), On 09/15/2022, the Nurse Manager conducted the Nursing Admission Screening/History assessment. Review of the assessment form	R 292	1. Retrospectively, corrective action cannot be accomplished for the resident is no longer in Assisted Living. 2. A review of all new admission in the past 90 days was completed to determine if a thorough physical assessment was completed. No other resident was affected. 3. License Nurses have been in-serviced on thorough physical assessment of all new admissions. The Clinical Manager will conduct monthly audit of all admissions x 3 months, then quarterly to ensure that a thorough physical assessment is completed on all new admission. The report of the audit will be submitted to the DON every month. 4. The result of these audit will be reviewed in QAPI quarterly meeting.	

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R 292	Continued From page 5 failed to show evidence that the presence of the resident's AV fistula was observed and assessed for the thrill and the bruit. Further review of the form revealed a section for a pulse assessment; however it was not specified on the form. There was no evidence that the resident's peripheral pulses were assessed. On 10/11/2022 at 3:09 PM, when asked about the above-mentioned deficiencies the Nurse Manager said that the pulses, she assessed were the radial pulses. She remembered looking at the resident's feet, noted that there were no issues, and did not assess the pulses in the resident's feet. It should be noted that on 09/24/2022 [eight days after admission] Podiatrist #2 evaluated the resident and found a 5 cm wound on her right heel. The resident's pedal pulses were absent and posterior tibialis pulse were faint in both feet according to the record. On 09/29/2022 [14 days after admission] Podiatrist #3 evaluated Resident #1 for a wound located on her right foot. At that time, the wound measured 2" X 1" or 5.08 cm x 2.54 cm. Also, the posterior tibialis pulses were not palpable, according to the records. It should be noted that on 10/05/2022, [20 days after admission], the wound specialist evaluated the resident and noted that the wound measured 13 cm x 4 cm x UTD. The wound had necrotic tissue with moderate drainage. The records showed that there was also a scab on the top of the right 1st toe. The resident was transported to the emergency room for further evaluation and treatment. After tests were completed and antibiotic treatments were implemented in the hospital it was determined that the resident would require either an above or below the knee	R 292		

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amputation. The resident's Power of Attorney (POA)/niece however declined surgery, opted to discontinue the resident's dialysis treatments, and request hospice services.

It should be further noted that on 10/31/2022 at 10:00 AM the ALR notified DC Health that Resident #1 passed away on 10/30/2022.

At the time of the investigation, the ALR's nurses failed to conduct thorough assessments to include evaluating the peripheral pulses.

II. The facility failed to ensure the nurses and consulting physicians timely documented care rendered to residents as evidenced below:

a), On 10/11/2022 at 11:00 AM, review of Resident #1's physician orders revealed that on 09/28/2022 (later discovered as an error, the order was written on 09/29/2022), Podiatrist #3 wrote an order for wound care to include applying Silvadene 1% cream to the Resident #1's right posterior heel and right dorsal wound every other day for three weeks. The podiatrist documented the first wound care and dressing on 09/29/2022. The next change was to occur on 10/01/2022. Review of the residents Medication administration Record (MAR) revealed that LPN #3 entered initials indicating that the wound care was performed, however review of the corresponding nursing note failed to show evidence that the wound care was performed as ordered.

On 10/11/2022 at 1:00 PM, the Unit Manager and the Director of Nursing, who were both present at the time of the document review acknowledged that the nurse should have documented the wound care in a nursing note. On 10/13/2022 at 1:30 PM, a review of a statement dated

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R 292	Continued From page 7 10/11/2022 written by LPN #3, showed that the wound care was completed on 10/01/2022, and that the nurse failed to document the care in a nurses note. b) On 09/24/2022, Podiatrist #2 evaluated Resident #1 and noted that the resident had a wound on her right heel (size not documented). The podiatrist treated the wound with Betadine dressing and documented that the resident was to receive Betadine dressings wound care treatment for 48 hours. Review of the resident's physician's orders and medication administration record failed to show evidence that the wound care was recommended and ordered. During a telephone interview with Podiatrist #2, he was asked about the wound care recommendation. Podiatrist #2 said he provided wound care to the resident from 09/24/2022 through 09/27/2022. When asked where he documented the wound care, he indicated that he did not document the care because he was doing it as a courtesy and was not billing for it. He indicated that he did not document the care on his consultation note but said that he should have documented the wound care. c), During interview on 10/11/2022 the Unit Manager said she received a photograph of Resident #1's heel wound on 10/03/2022 from LPN #1. A review of the corresponding progress notes revealed LPN #1 documented the assessment of the residents AV fistula but failed to show evidence that a wound was observed, and if treatment was rendered. At the time of the investigation, the facility failed to ensure the nurses and consulting physicians document care rendered to Resident #1.	R 292		

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III. The nursing staff and consulting podiatrist failed to document the healing status of Resident #1's wounds as evidenced below:

On 10/17/2022 at 4:30 PM, review of the ALR's Pressure Ulcers/Skin Breakdown - Clinical Protocol revealed that ...The nurse shall describe and document the following:

a. Full assessment of pressure sore including location, stage, length, width, and depth present, exudate, or necrotic tissue.
b. Pain assessment.
c. Resident's mobility.
d. Current treatments, including support surfaces; and
e. All active diagnoses ...

a) On 10/11/2022 at 1:20 PM, review of a progress note dated 10/02/2022 revealed LPN #3 documented "treatment to the right hill (heel) done. No drainage or odor noted. Wound still covered with scab ..." The nurse failed to document the length, width, and depth of the wound to determine the status of the wound's healing stage.

The registered nurse (RN), and director of nursing (DON) who was present at the time of the review acknowledged that the nurse did not document the characteristics of the wounds as per the ALR ' s policy.

b), On 10/19/2022, at 3:09 PM, review of an Encounters and Procedures summary showed that Podiatrist #2 evaluated Resident #1 on 09/24/2022. Further review of the form showed that the podiatrist observed an intact hematoma on the resident's right big toe (hallux) with redness but no swelling ... The right heel had a

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posterior pressure wound with redness, drainage, swelling pain but no odor ... The report did not provide the dimensions of the wounds. There was no corresponding progress note in the resident's record.

During interview with Podiatrist #2 on 10/19/2022 at 2:08 PM, he was asked about the size of the wounds on Resident #1's right foot. The podiatrist indicated that the wound was "about 5 cm. in diameter." He said that he treated the wound with Betadine from 09/24/2022 through 09/27/2022, and when asked if he documented the daily wound care provided, he said he did not document the care, because he did it as a courtesy and follow-up. When asked about the condition of the wound while he was caring for the wound he said, "there was no worsening of the wound."

c), During interview on 10/11/2022 the Unit Manager said she received a photograph of Resident #1's heel wound on 10/03/2022 from LPN #1. A review of the corresponding progress notes revealed LPN #1 documented the assessment of the residents AV fistula but failed to show evidence that a wound was observed, and if treatment was rendered. During an interview on 10/19/2022 at 10:10 AM, LPN # 1 said certified nursing assistant (CNA) #1 informed her that Resident #1's foot was bleeding. When she arrived at the resident's room and removed the dressing, she saw that there was necrosis and slough on the surrounding tissues. I took a picture of it and sent it to the unit manager. She acknowledged that she did not measure the wound.

At the time of the investigation the facility's nurses and consulting physicians failed to document the

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healing status of the wound on Resident #1's right heel.

IV. The facility's nursing staff, and consulting physicians failed to notify the PCP of changes in a resident's condition i.e., right foot wounds as evidenced below:

A. During interview with the Unit Manager/RN on 10/11/2022 at 10:00 AM she indicated that on 10/03/2022, LPN #1 sent her the picture of Resident #1's heel wound. She said that the next day, she requested that the resident be seen by the wound specialist. When asked if the PCP was made aware of the wound, she said she had not notified the PCP, and added that was her first-time hearing about the wound.

B. On 09/24/2022 Podiatrist #2 evaluated Resident #1's feet and noted wounds to her right big toe (hallux) and heel. He also documented that the resident's dorsalis pedis and posterior tibial artery pulses were either not palpable or faint and treated the wounds with Betadine for four days. Review of the resident's record failed to show evidence that Podiatrist #2 documented that he provided wound care for four days on his consultation form nor did he document notifying the PCP about the wounds. During an interview with Podiatrist #2 on 10/19/2022 at 2:08 PM, he admitted that he did not write orders for wound care, nor did he notify the PCP (or the facility's nurses) about the resident's wounds.

C. Podiatrist #3 evaluated Resident #1 on 09/29/2022. The podiatrist indicated that the resident's wounds were 2" x 1" (5.08 cm x 2.54 cm) and that the resident's dorsalis pedis and posterior tibial artery pulses were either not palpable or faint. During an interview with

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Podiatrist #3 on 10/19/2022 at 3:47 PM, he acknowledged that he wrote orders for wound care, i.e., Silvadene cream every other day on 09/29/2022. When asked if he informed the PCP about the resident's wounds, the recommended treatment, and the non-palpable pulses, he indicated that it was not a practice for him to contact the PCP himself, he expected the nurses to inform the PCP. He indicated that he told the aide that was in the room but did not know that she was not an employee of the ALR.

D. During an interview on 10/19/2022 at 10:10 AM, LPN #1, said that she saw the order for the Silvadene Cream and the dressing changes on 09/30/2022. She said the order stated per the PCP's "OK." When asked if she notified the PCP about the order, she said she showed the order to her co-worker but did not inform the PCP. LPN #1 further stated that on 10/03/2022 a Certified Nursing Assistant (CNA) #2 informed her that Resident #1's heel was bleeding. When she went to tend to the resident, she saw that the wound looked bad. She said she took a picture of the wound and sent it to the unit manager. When asked if she informed the PCP about the wound, she said she did not.

At the time if the investigation, the facility's nurses, and consulting physicians failed to notify the PCP of changes in a resident's condition i.e., right foot wounds.

It should be noted that the wound specialist and the nurse practitioner evaluated the resident's wound on 10/05/2022 and determined that the resident needed immediate attention and treatment. The resident was transported to the emergency room where a Doppler study revealed the resident's right superficial femoral artery was

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R 292	Continued From page 12 occluded. V. The ALR failed to have documented evidence that the PCP was made aware of consultant's recommendations as evidenced below: On 10/19/2022 at 3:00 PM, review of podiatry consultations dated 09/24/2022 and 12/04/2021, revealed that Podiatrist #2 recommended "larger toe boxed shoe-gear with mesh fabric to reduce friction and accommodate contracted digits." Further review of the record failed to show documented evidence that the PCP reviewed the consultant's evaluation or was made aware of the recommendation by the nurses or the Podiatrist. During an interview with the ALR's Director on 10/24/2022, she was asked about the process for ensuring the PCP was made aware of a consultant's recommendations. The Director said the Charge Nurse will contact the PCP and inform him of the recommendation, and to document the conversation in the progress notes. If the PCP agrees with the recommendation, he will write an order. Review of the Sept. 2022 nursing notes failed to show evidence that the PCP was made aware of the podiatrist's recommendation. It should be noted that the 09/29/2022 podiatry assessment revealed that the resident had " ...a tight-fitting shoe ..." and "pitting edema was notable. At the time of the investigation there was no evidence that the ALR's PCP was notified about recommendations made by the podiatrist. VI. The ALR's PCP failed to include peripheral vascular disease (PVD), as identified by the Podiatrists, with Resident #1's active diagnoses as evidenced below:	R 292		

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Review of Resident #1's podiatry assessments on 11/19/2022 showed Podiatrist #2 evaluated the resident on 12/04/2021 and 09/24/2022. The assessment revealed the resident's dorsalis pedis pulse was not palpable and her posterior tibialis pulse was faint in both feet. The podiatrist's assessment revealed the resident had peripheral vascular disease ("PVD), and other maladies of the foot. On 09/24/2022 the resident developed a 5 cm wound on the right foot.

Podiatrist #3 evaluated the resident on 09/29/2022, and the assessment revealed Resident #1's dorsalis pedis pulse was faint and her posterior tibialis pulse was not palpable. The podiatrist assessment revealed the resident had peripheral artery disease (PAD), as well as a wound on her right foot."

On 10/11/2022 at AM, a review of Resident #1's 09/15/2022 physician's orders revealed the resident had diagnoses that included: hypertension, dementia, anemia, and end stage renal disease (ESRD). Review of the physician's pre-admission assessment showed that the resident's primary diagnosis was fracture of the left femur, and her secondary diagnosis was fracture of the left pubis and hypertension. Review of the resident's ISP document showed the following diagnosis: essential primary hypertension, edema unspecified, chronic kidney disease Stage 5, unspecified dementia unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance and anxiety, anemia in chronic disease, insomnia unspecified, major depressive disorder, recurrent unspecified, and dependence on renal dialysis.

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R 292	Continued From page 14 During an interview on 10/19/2022 at 3:47 PM, Podiatrist #3 stated that the diagnoses of PVD and venous stasis was known previously, and that the resident had a history of vascular disease. There was no evidence that the PCP identified PVD/PAD as active diagnoses for Resident #1. At the time of the investigation the ALR's PCP failed to include peripheral vascular disease, as identified by the Podiatrists, with Resident #1's active diagnoses	R 292		
R 389	Sec. 509a Abuse, Neglect, and Exploitation. (a) An ALR shall develop and implement policies and procedures prohibiting abuse, neglect, and exploitation of residents. Based on interview and record reviews, the Assisted Living Residence (ALR) failed to develop and implement policies and procedures to prevent neglect that addressed 1), the timely receipt of assessment reports of consultants, 2), documenting the Primary Care Physician (PCP) and nursing review of the consultant's reports, 3), documenting if the PCPs agrees or disagrees with the recommendations made by the consultant, 4), the Charge Nurse [LPN] timely reporting changes in a resident's condition to the Unit Manager [RN], and 5), a system for privately contracted personnel (Home Health Aides) to document care activities rendered, observed care rendered by others and changes in client condition for one of one resident in the investigation (Resident #1). Findings included: According to the ALR's Abuse Prevention policy	R 389		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0003	A. BUILDING: ______ B. WING ______	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE METHODIST HOME OF DC- FOREST HILLS	4901 CONNECTICUT AVENUE NW WASHINGTON, DC 20008

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R 389	Continued From page 15 dated 08/25/2021, neglect was defined as "the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." The ALR's nursing staff and medical staff and consultants failed to 1. The facility failed to develop and implement policies and procedure to address the timely receipt of the results of a consultant's assessment report as evidenced below: On 09/24/2022 and 09/29/2022, Podiatrists #2 and #3 assessed Resident #1, provided wound care and recommended wound treatments. During an interview on 10/19/2022 at 3:12 PM, the facility's Nurse Practitioner (NP) was asked if she had seen the podiatrists' assessments prior to 10/05/2022. The NP said that she had not seen the assessments, nor had they been faxed to the PCP's office. She further stated that the podiatrist had not sent his note to the facility prior to 10/05/2022, and that she did not know anything about the wound prior to that day. She said no one voiced any concerns about the resident's feet. When asked if the consultants document their findings in the resident's record prior to their typed report being sent to the facility, the NP said they should put a note in the chart, however what they do is they see the patients and then go home and type their notes. During interview on 10/19/2022 at 2:08 PM, Podiatrist #2 was asked how long it takes to get the report of his assessment to the facility. He said, "it takes five (5) days." During an interview on 10/24/2022 at 11:19 AM, the ALR's Director was asked if the facility had a policy to address the timeliness of receiving the outcomes of a consultant's	R 389	1. Upon discovery, the facility immediately updated our policies and procedure to include how to address the timely receipt of the results of a consultant's assessment report.	10/19/2022
			2. Audit of all residents seen by the Podiatrist in the past 60 days was conducted for timely receipt of consultation report, 7 residents were identified. No residents were adversely affected.	10/24/2022
			3. Clinical consultants and License Nurses have been in-serviced that upon the consultation the report must be provided to the Charge Nurse/Designee before exiting the facility (in the case of an outside consultant, the consultation report must be provided to resident upon return from consulting physician). The Charge Nurse/ designee have been also been in-serviced to communicate the consultation recommendations to the PCP. The Clinical Manager or designee will conduct monthly audit of-consultations x 3 months then quarterly, report of audit will be submitted to the DON.	11/30/2022
			4. The results of these audit will be reviewed in QAPI quarterly meeting.	Ongoing

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 389	Continued From page 16 assessment. The Director said, there was no policy to address this issue. 2. The facility failed to develop and implement policies and procedure to address the evidence of when the PCP and nurses reviewed a consultant's report as evidenced below: Podiatrists #2 and #3 assessed resident #1 on 09/24/2022 and 09/29/2022 respectively. A review of the corresponding nursing progress notes and the Nurse Practitioner's (NP) notes failed to show evidence that the PCP, the NP, and the ALR's nurses acknowledged the Podiatrists evaluation and recommendations based on the assessment. When asked if the consultants document their findings in the resident's record prior to their typed report, the NP said they should put a note in the chart, however what they do is they see the patients and go home and type their notes. During interview on 10/19/2022 at 2:08 PM, Podiatrist #2 was asked how long it took to get the report of his assessment to the facility. He said, "it takes five (5) days." When asked if he left a note in the chart when he sees the residents, he said no. During an interview on 10/24/2022 at 11:19 AM, the ALR's Director was asked if the ALR had a policy or procedure to address how the ALR knows when the PCP or NP reviews a consultant's reports. The director indicated that there were no procedures in place to address the issue. 3. The facility failed to develop and implement policies and procedure to address documenting if the PCPs agrees or disagrees with the recommendations made by a consultant as evidenced below: On 09/24/2022 Podiatrist #2 recommended that	R 389		

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R 389	Continued From page 17 Resident #1 wear "larger toe boxed shoe-gear with mesh fabric to reduce friction and accommodate contracted digits." In addition, on 09/29/2022 Podiatrist #2 evaluated Resident #1 and recommended applying Silvadene 1% cream to the wounds on Resident #1's right foot. Review of the September 2022 nursing notes failed to show evidence that the nurses informed the PCP about the podiatrists' recommendations. During an interview with the ALR's Director on 10/24/2022, she was asked about the process for ensuring the PCP is made aware of a consultant's recommendations and if there was a policy that outlined the process. The Director said the Charge Nurse will contact the PCP and inform him of the recommendations, and then document the conversation in the progress notes. If the PCP agrees with the recommendation, he will write an order. The Director also said that the ALR had not developed a policy to address the issue. At the time of the survey, the ALR failed to develop and implement policies and procedures to address timely receipt, review and disposition of consultant assessments and recommendations.	R 389		