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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	C 04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted at your facility April 6, 2022, by the Department of Health, Health Regulation and Licensing Administration, in accordance with 42 CFR 483.73. Based on record review and staff interview, it was found that the facility was in compliance with Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility census was 255.	E 000		8/24/22
F 000	INITIAL COMMENTS On March 26, 2022, an unannounced complaint survey was initiated at this facility. After review of facility documentation and conferring with CMS-Philadelphia management, this survey was converted into an annual recertification survey on March 29, 2022. This survey took place onsite at the facility from March 26, 2022 - April 20, 2022. Survey activities consisted of a review of 105 sampled residents. The facility's census during the survey was 255. The following complaints were investigated during this survey: DC00010689, DC00010640, DC00010663, DC00010638, DC00010532, DC00010531, DC00010525, DC00010503, DC00010493, DC00010435, and DC00010365. The following facility reported incidents were investigated during this survey: DC00010721, DC00010720, DC00010719, DC00010717, DC00010694, DC00010656, DC00010651, DC00010645, DC00010644, DC00010636, DC00010634, DC00010618, DC00010584, DC00010575, DC00010576, DC00010565, DC00010547, DC00010539, DC00010540,	F 000	Deanwood Rehabilitation and wellness center Disclaimer: The facility submits this plan of correction under procedures established by the department of Health in order to comply with the departments directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of alleged deficiencies or any admission of any wrongdoing.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 8/22/22

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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DC00010485, DC00010464, DC00010471, DC00010443, DC00010438, DC00010412, DC00010405, DC00010400, DC00010373, DC00010335, DC00010334, DC00010332, DC00010330, DC00010328, and DC00010314.

Federal and Local deficiencies were cited related to the investigation of: DC00010721, DC00010694, DC00010656, DC00010689, DC00010663, DC00010651, DC00010640, DC00010634, DC00010584, DC00010576, DC00010565, DC00010525, DC00010503, DC00010485, DC00010464, DC00010443, DC0001010435, DC00010405, DC00010365, DC00010336, DC00010334, DC00010330, DC00010314,

This survey did identify substandard quality of care at 42 CFR 483(c)(2)(3)(4) F610 and 42 CFR 483.25(d)(2) F689. The extended survey was conducted on April 20, 2022.

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. Substandard quality of care was identified at F689 and F610 and the survey team conducted the extended survey on April 20, 2022.

The following deficiencies are based on observation, record review, and resident and staff interviews.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status

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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)
M- minute
mL - milliliters (metric system measure of

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F 000	Continued From page 3 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 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		8/24/22
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550	F 550 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #64 was assessed from head to toe on 4/26/22 by Unit Manager, resident is free from odor. Resident suffered no negative outcomes. MD/RP notified on 4/26/22 Resident #180 was assessed from head to toe on 4/26/22 by Unit Manager, resident suffered no negative outcomes. MD/Notified on 4/26/22. Resident was provided with a urinal and taught proper use of the urinal. Return demonstration indicated understanding. Room was cleaned and free from urine odor. Resident was encouraged to use the bathroom. Staff encouraged to ensure resident is using his urinal correctly. Resident will be assessed for toileting program immediately but no later than 8/24/22. Room and bathroom floor was cleaned immediately and will be cleaned daily by housekeeping staff.	

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F 550	Continued From page 4 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 105 sampled residents, facility staff failed to ensure that Resident #64 was treated with respect and dignity evidenced by failure to	F 550	THE POTENTIAL TO BE AFFECTED All residents with independent level of care have the potential to be affected. House wide audit will be conducted by The Director of housekeeping or Designee to ensure that all the rooms and bathrooms are cleaned and free from urine odor. Any issues found will be corrected by 8/24/22 House wide audit will be conducted by the Director of Nursing and Unit Managers to ensure that there no other residents are urinating on the floor. Any issues found will be corrected by 8/24/22 MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Educator to all housekeeping staff to ensure that all rooms and bathrooms are always cleaned and free from odor by 8/24/22 In service will be provided to the nursing staff by the Staff educator/ Designee on the importance of making sure that residents who are using urinals are using it appropriately by 8/24/2022	8/24/22

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F 550	Continued From page 5 provide an environment that enhances the resident's quality of life, was based on his individuality and medical condition. The findings include: Resident #64 was admitted to the facility on 04/29/15 with diagnoses that included: Acquired Absence of Unspecified Leg below Knee, Pathological Fracture, Unspecified Femur, Initial Encounter for Fracture, Muscle Weakness (Generalized), Spinal Stenosis, Site Unspecified. According to the quarterly Minimum Data Set dated 01/22/22, the resident was coded as "15" under Section C0500 BIMS Score indicating that he is cognitively intact. Under Section G0110 Functional Status, the resident was coded as "3", indicating he required extensive assistance for toilet use, with one-person physical assist. Under Section G0110 Functional Status, the resident was coded as "3", indicating he required extensive assistance for personal hygiene, with one-person physical assist. Under Section H (Bladder and Bowel) the resident was coded as such: H0200 (Urinary Toileting Program) = No H0300 (Urinary Incontinence) = 2, indicating he was frequently incontinent H0400 (Bowel Continence) = 2, indicating he was frequently incontinent	F 550	5Unit Managers will make frequent rounds during their shift to ensure that residents are not urinating on the floor. Any issues found will be corrected by 8/24/22 Charge nurses will ensure that all residents are provided ADL care daily and ensure they are free from urine odor. Any issues found will be corrected by 8/24/22. Ambassadors' rounds will be conducted by interdisciplinary team members (social services team, activities, nursing) to ensure their rooms and bathrooms are clean and free from odor. Any issues found will be addressed by 8/24/22. Resident *will be assessed for bladder training by Unit Manager by immediately but no later than 8/24/22. If qualified, resident will be started on a bladder training exercise. Room cleaning schedule will be provided to Unit managers by housekeeping staff by 8/24/2022 to assist them to validate weekly that the rooms and bathrooms are cleaned and free of odor. Unit manager will ensure resident # 64 is treated with dignity and respect during their shift.	8/25/22

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F 550	Continued From page 6 H0500 (Bowel Toileting Program) = No During an environmental tour on 03/30/22, at approximately 4:00 PM, a strong urine odor was present in the bathroom that services the residents in room #515 and #516 on unit 5 North. Resident #64, in room #516, complained that Resident #180, in room #515 frequently urinates on the bathroom floor, and smears the bathroom with feces. He said that although he would like to use the toilet, he does not, because of the smell. This, he said, has been going on since Resident #180, in room #515, moved in sometime last year. Resident #64 said, as a grown man, he is embarrassed to have staff clean him and change his diaper, but he has no choice. Staff is aware he said, and staff has even seen Resident #180 urinate on the floor. When asked if he would like to move, Resident #64 said he was not moving because of Resident #180's behavior, and he was told a long time ago that the resident who complains is the one who should move. Face-to-face interviews were conducted on 04/07/22, between 1:15 PM and 2:00 PM: Employee #51 (RN on 5 North) confirmed that Resident #180 often urinates on the floor, in his room and in the bathroom. He also gets feces on his hand and under his nails. Staff is aware of these behaviors and clean his hands and nails regularly. Employee #51 said that Resident #64 will sometimes ask for help to go to the bathroom but mostly uses diapers.	F 550	MONITORING CORRECTIVE ACTIONS: The Director of Nursing(DON) / Designee, the housekeeping director, will conduct validation rounds, weekly to confirm that all rooms are cleaned and free from odor. Any issues found will be addressed by 8/24/22. Floor cleaning schedule will be given to Unit Managers by housekeeping staff to be used during the validation process. The Unit Managers will conduct rounds to ensure no resident is urinating on the floor and that the floors are clean. This audit will be done weekly x 4 and then monthly x3. and report presented to QAPI Committee.	8/24/22

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Employee #52 (CNA) said that Resident #180 sometimes urinates on the floor in his room and in the bathroom, and his hands must be cleaned every time he goes to the bathroom because he gets feces on his hand. Staff is aware of Resident #180 behavior, and he documents it.
Employee #52 further stated, Resident #64 uses a diaper and does not get up.

Employee #50 (CNA) said that Resident #180 pees on the floor, gets poop on his hands and messes up the bathroom. Resident #64, she said, uses the diapers.

Employee #53 (CNA) has worked on 5 North for 5 years. She also said that Resident #180 pees on the floor and gets feces on his fingers when he tries to wipe himself. Nursing staff is aware, and she documents it.

Employee #53 stated that Resident #180 used to go to the toilet but " ... stopped using the toilet because it ' s always messy".

A review of Resident #64's medical records on 04/08/22 at approximately 10:00 AM on show a care plan for Bowel Irregularity with specific interventions to "encourage resident to sit on toilet to evacuate bowels if possible". However, through resident and staff interviews, there were no indications that Resident #64 is urged by staff to use the toilet.

Employee #54 alternates as a RN between 5 North and 5 South. During a face-to-face interview on 04/08/22, at 10:35 AM, he revealed that Resident #64 uses diapers only and acknowledged the findings.

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F 558 SS=D	Continued From page 8 Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, for one (1) of 105 sampled residents, the facility's staff failed to provide Resident #113 access to the bathroom and an elevated toilet seat causing the resident to be dependent on staff to use the bathroom. The findings include: During an observation on 03/29/22 at approximately 11:30AM, Resident #113's bathroom was locked, and the surveyor had to access the bathroom from the neighbor's side. It was also observed that the bathroom did not have an elevated toilet seat. Resident #113 was admitted to the facility on 06/19/14. The resident has a history of General Muscle Weakness, Generalized Arthritis, Difficulty Walking, and Osteoporosis. Review of a Quarterly Minimum Date Set dated 02/09/22 showed Resident #113 had a BIMs summary score of "15," indicating the resident had intact cognition. Further review of the MDS revealed Resident #113 was coded for needing supervision and requiring the physical assistance of one person for toilet use, not moving on and off	F 558 F 558	CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #113 was assessed from head to toe on 4/26/22 by Unit Manager. Resident suffered no negative outcomes. MD/RP notified on 4/26/22.Unit manager ensured that resident has access to the bathroom. Rehab team will provide an elevated toilet seat in the resident's bathroom immediately but no later than 8/24/2022. Unit Manager taught and instructed resident in the next room to residents #113's room to always leave the bathroom door unlock when not in use on 4/26/2022. . IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents with shared bathroom have the potential to be affected. House wide audit will be conducted by DON/Designee to identify resident who need elevated toilet seats. Any issues found will be corrected by 8/24/22 House wide audit will be conducted by Unit Managers and the maintenance team to ensure shared bathroom can easily be accessible by the residents. Any issues found will be corrected by 8/24/22.	8/24/22

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F 558	Continued From page 9 the toilet during this assessment period, not being steady and requiring staff assistance for stability during surface-to-surface transfers, and using a wheelchair. Additionally, the resident was coded for occasional urinary incontinence and frequent incontinence of bowel. Review of physician's orders from 06/19/14 to 04/12/22 lacked documented evidence of an order for an elevated toilet seat. Review of a care plans showed the following: Focus Area- [resident's name] has occasionally urinary incontinence related to loss of bladder muscle tone (revision date of 12/03/19). Interventions: -Brief use: the resident uses disposable briefs. Change when wet and prn (as needed). -Check for incontinence frequently and provide incontinent care as needed. Focus Area -[resident's name] has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) disease process CVA (Cerebral Vascular Accident). Goal- [resident's name] will improve current level of function in transfer and personal hygiene. Intervention-toilet resident upon arising, after meals and at bedtime. Review of an invoice dated 11/11/21 showed that the facility ordered a Bariatric Commode [an elevated toilet seat that's placed over a toilet]. During a face-to-face interview on 03/29/22 at approximately 2:00 PM, Resident #113 stated that her next-door neighbor, who she shares a bathroom with, keeps the bathroom door locked, so she cannot access the bathroom. The resident	F 558	4Supervisors will monitor weekly to ensure residents with shared bathroom always have access to the bathroom. Any issues found will be addressed by 8/24/22 MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Educator to all CNA's on the importance to notify the charge nurse if a resident is having difficulties using the bathroom because of inappropriate toilet seat so that proper intervention is implemented by 8/24/2022. Charge nurse will notify the therapy team when they get report that a resident is having difficulties using the toilet so the resident can be assessed for the use of an elevated toilet seat. Any issues found will be corrected by 8/24/22 Therapy team will ensure residents who need elevated toilet seat are assessed and provided one by 8/24/2022 to ensure that residents will have no difficulty using the toilet. Nurse aides are encouraged to frequently check the bathroom door between room 315 and room 316 and other shared bathrooms to ensure the bathroom door is unlocked and accessible to both residents during their shift. Any issues found will be corrected by 8/9/22.Unit manager will ensure resident # 113 has access to the bathroom by 8/24/22	8/24/22

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F 558	Continued From page 10 also said that not having access to the bathroom was "ok" because the toilet is too low, and she can not independently transfer from the toilet to her wheelchair. When asked how she uses the bathroom, Resident #113 said that she uses the brief (incontinent pad), cleans herself up, and calls staff to remove the used brief. During a face-to-face interview on 04/12/22 at 2:59 PM, Employee #59 (Restorative Aide) stated that she had not worked with the resident on transferring from the toilet to the wheelchair because the resident needed an elevated toilet seat. During a face-to-face interview on 04/12/22 at 3:40 PM, Employee #55 (Occupational Therapist) stated, "We ordered her an elevated toilet seat, but it never came in." The employee said that she made her supervisor aware the resident's elevated toilet seat had not been delivered. During a face-to-face interview on 04/12/22 at 3:15 PM, Employee #56 (Certified Nursing Assistant) stated that she had worked with the resident for about a year, and the resident does not call for assistance for the bathroom. The employee stated that the resident "changes herself" when she soils her brief. Employee #56 then said that when Resident #113 changes her soiled brief, she puts it in a trash bag and calls the desk saying, "Come get the trash."	F 558	Unit manager / Designee will educate (remind) residents who share a bathroom with other resident in the adjoining room, to leave the door unlocked when not in use. Findings will be corrected by 8/24/22 Activities Director will also educate (remind) residents during resident council meeting to leave the bathroom door unlocked when not in use, MONITORING CORRECTIVE ACTION DON /Designee will conduct weekly rounds to ensure all residents who need elevated toilet seats are assessed by the rehab team and assigned one if applicable by 8/24/22 Maintenance team will conduct rounds during their shift to ensure that shared bathrooms are easily accessible by both residents, any issues found will be addressed and reported to QAPI director /committee weekly x4, then monthly x3	8/24/22
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561		

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F 561	Continued From page 11 through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews for one (1) out of 105 sampled residents, facility staff failed to offer a resident who had been moved due to a COVID-19 outbreak, the opportunity to move back to her previous room or previous unit once COVID-19 precautions were lifted. Resident #233. The findings include: Resident #233 was admitted to the facility on 05/26/21 with diagnoses including Diabetes	F 561	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS Resident #233 was assessed from head to toe on 4/26/22 by Unit manager, resident suffered no negative outcome. Resident stated that she likes her new room. RP/MD notified on 4/26/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Residents who are being relocated secondary to Covid 19 have the potential to be affected. House wide audit was conducted by Unit Mangers/ Designee to identify residents whom the facility admissions coordinator failed to relocate back to their previous rooms after they have completed their isolation / quarantine days for past two months. No resident complained that he or she wanted to be relocated.	8/24/22

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F 561	Continued From page 12 Mellitus with Diabetic Neuropathy, Chronic Kidney Disease, Stage 4, and Cerebral Infarction Due to Unspecified Occlusion or a Stenosis of Unspecified Cerebellar Artery. Quarterly Minimum Data Set dated 03/16/22 facility staff coded Resident #233 in the following manner: Section C (Cognitive Patterns) Brief Interview for Mental Status Summary Score was 15, indicating that the resident was cognitively intact. A review of Resident #233's medical record revealed: 01/01/22 at 9:53 AM [Activities Note -In-house Transfer]: "[Resident #233's Name] was relocated from Room 209B to Room 502A as a precautionary measure related to Covid-19." During an observation on 03/31/22 at 11:30 AM, the writer observed Resident #233 in her room resting in her bed. On the bedside table was one trash bag with some of the Resident's belongings in them. Another trash bag with the Resident's belongings was sitting in a chair adjacent to the resident's bed. During a face-to-face interview with the resident at the same time as the observation, she explained there was no place to put her clothes because the closet was locked and still had the former male resident's belongings in it. She further expressed that she wanted to go back to her old room on the second floor. She said when she was first moved to the fifth floor, she was told the move was temporary, but the facility staff hadn't said anything since. The resident then asked the writer to speak with her Representative about concerns with the room.	F 561	F561 MEASURES TO PREVENT RECURRENCE: *In-service will be provided by Staff Educator to all nursing staff members on the importance of asking residents if they desire to be relocated to their previous room after isolation /quarantine and put a documentation in place by 8/24/2022. Unit Managers will conduct rounds during their shift to ensure all residents who are due for relocation post isolation and quarantine are given the opportunity to determine if they wish to go back to their previous room or not. Any issues found will be corrected by 8/24/22. In-service will be provided to the admissions coordinator, nursing staff and Licensed social workers on the importance of ensuring that residents are given the opportunity to state if they want to go back to their previous room or not. Documentation of outcome will be in place by 8/242022. Admission coordinator will read the list of residents who are due for relocation post quarantine / isolation to the interdisciplinary team (social workers, Activities director, clinical staff) during morning meetings to remind them of the relocation date so that plans can be made to meet with the resident to determine if they desire to move or not. Any issues found will be corrected by 8/24/22.	8/24/22

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F 561	Continued From page 13 During a telephone interview on 04/01/22 at 12:07 PM with Resident #233's representative/daughter she voiced the following concerns: "In early January 2022, my mother was moved due to a COVID outbreak in the facility. I am not sure how that was decided or what criteria they used. She was doing fine in a room with one roommate and was put in a room with three other residents. They put her in a room with no tv, no phone, and no place to put her clothes. We thought the move was only going to be temporary..." During a face-to-face interview on 04/06/22 at 12:51 PM Employee #13 (Social Worker), stated that she was aware of Resident's #233's room transfer from the second to the fifth floor. When asked if anyone had offered the resident the opportunity to move back to her old room or unit, she responded, "The resident never told me that she wanted to move back." During a face-to-face interview on 04/06/22 at 12:51 PM, Employee #44 (Admissions Director), stated, "When a resident wants to transfer to another room, the resident usually lets the social worker or nurse know, and then I let the social worker or nurse know what room(s) are available. With Resident #233, I had been speaking with her daughter/representative. The last time I spoke with her was back at the beginning of February. There were no rooms available on the resident's old unit at that time. Rooms on the resident's old unit [second floor] became available mid-February. I have 9-10 rooms available now. I was going to call her representative today and let her know the resident's old unit, has rooms available."	F 561	F 561 MONITORING CORRECTIVE ACTIONS: ADON/ Designee will conduct rounds to ensure residents who have completed their isolation/ quarantine days are off the unit. Residents who wish not to be relocated to their original rooms must indicate by documenting their desire to stay in the room. The responsible party will be updated of this decision. These audits will be conducted weekly x4 and monthly x3. Any issues will be corrected and reported to the QAPI committee.	8/24/22

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F 561	Continued From page 14 After the COVID-19 outbreak, there was no documented evidence that facility staff offered Resident #233 the opportunity to return to her original room or unit.	F 561		8/24/22
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582	F 582 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: This deficient practice cannot be retroactively corrected because: Resident #209 was discharged home 3/12/22 Resident #553 was discharged home 1/22/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Residents who are due for discharge have the potential to be affected. Licensed Social services team members will conduct house wide audit to identify residents who are due for discharge and ensure they are provided their NOMNC form no later than four days before the discontinuation of their skilled services. Any issues will be corrected by 8/24/2022.	

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F 582	Continued From page 15 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 105 sampled residents, facility staff failed to ensure that two (2) residents or their representative was provided the NOMNC form no later than noon of the day before the effective date indicated/date listed as discontinuance of skilled services. Residents' #209 and #553. The findings include: "The Notice of Medicare Non-Coverage form stipulates that every Medicare resident in a facility has the right to appeal the decision of non-coverage to the Quality Improvement Organization...The Quality Improvement Organization will notify you of its decision as soon as possible, generally no later than two days after the effective date of the notice if you are in	F 582	MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Educator to all social services workers on the importance of ensuring that residents who are due for discharge are notified of the discontinuation of their skilled services at least four days in advance. This will be completed by 8/24/2022. Repeat in-service will be done as needed. Rehab Director will notify the interdisciplinary team members (clinical staff, activities staff, nutritionist) of the number of days left for skilled residents have during daily morning meetings, so that everyone will be on the loop to ensure a timely discharge. Any issues found will be corrected by 8/24/2022. MDS coordinators will assist in determining when a resident is close to discontinuation of skilled services, so that the cut off letter can be presented to the resident or the responsible party in a timely manner. Any issues found will be corrected by 8/24/2022.	8/24/22

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F 582	Continued From page 16 Original Medicare..." 1. Resident #209 was admitted to the facility on 02/16/22, with diagnoses that included Chronic Obstructive Pulmonary Disease, Anemia, Hypertension, and Vertebral Sacral Fracture. According to the NOMNC form, Resident #209's last day of coverage for Skilled Nursing Services was March 21, 2022 ...Explained NOMNC and appeal rights. Made aware of effective date- 03/21/22 and the resident financial liability beginning date was 03/22/2022. Facility staff failed to ensure that Resident #209 or their representative was provided the NOMNC form no later than noon of the day before the effective date indicated/date listed as discontinuance of skilled services. 2. Resident #553 was admitted to the facility on 01/06/22, with diagnoses that included Kidney Transplant Status, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Asthma, End Stage Renal Disease and Heart Failure. According to the NOMNC form, Resident #553's last day of coverage for Skilled Nursing Services was 01/18/22 ...Explained NOMNC and appeal rights. Made aware of effective date- 01/18/2022 and the resident financial liability beginning date was 01/19/22. Facility staff failed to ensure that Resident #553 or their representative was provided the Notice of Non-Coverage no later than noon of the day before the effective date indicated/date listed as discontinuance of skilled services.	F 582	F 582 MONITORING CORRECTIVE ACTION: Licensed Social Services team members will ensure that residents who are due for discharge are given their NOMNIC at least four days prior to the date listed as discontinuance of their skilled services. This audit will be conducted weekly x4 and monthly x 3. Any issues found will be addressed and reported to QAPI committee.	~~8/24/22~~

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F 582	Continued From page 17 During a face-to- face interview on 04/20/22 at 10:33 AM, Employee #10 (Director of Social Services) reviewed Resident #209's and #553's documents and acknowledged the findings.	F 582		8/24/22
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584	4F584 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: All rooms and bathrooms will be audited, to ensure that they are clean and free from odor, and that the environment is clean and homelike .Any issues found will be corrected by 8/24/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All rooms in the facility have the potential to be affected by this deficient practice. Damaged privacy curtains in rooms #211, #308, #309,#310, #311 NA #329 are presently clean and undamaged. Room #420, #428, #502, #516, #524 are presently cleaned with no smell of urine noted. Bathroom vents in rooms # 401, #405,#428, #420, #529 are presently clean. Air conditioners in rooms 329,#508, #524 were checked. Any issues found will be corrected by 8/24/22.	

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F 584	Continued From page 18 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by damaged privacy curtains in six (6) of 76 resident's rooms, soiled bathroom vents in five (5) of 76 resident's rooms, a foul, offensive odor in (5) of 76 resident's rooms and malfunctioning packaged terminal air conditioner (PTAC) units in three (3) of 76 resident rooms. The findings include: During an environmental walkthrough of the facility on 03/30/22, at approximately 4:00 PM, and on 04/04/22, between 10:00 AM and 3:45 PM, the following was observed: 1. Privacy curtains were torn and separated from the rails in six (6) of 76 resident's rooms including rooms #211, #308, #309, #310, #311, and #329. 2. Bathroom vents were soiled with dust in five (5) of 76 resident's rooms specifically rooms #401, #405, #428, #420, and #529. 3. A strong urine odor was evident in resident	F 584	F584 MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Development team to the housekeeping and maintenance team members on the importance of ensuring that all residents rooms have privacy curtains that are in good condition, that all bathroom's vents are clean and in good working condition, that the rooms are free from urine odor and that all air conditioners are clean and functioning well. This will be completed by 8/24/2022. Repeat in-service will be provided as needed. Unit Managers will conduct rounds on their units weekly to ensure that the privacy curtains , bathroom vents, air condition units are in good condition and functioning properly. Any issues found will be corrected by 8/24/22. Maintenance and housekeeping team will conduct daily rounds in all the rooms to ensure that all privacy curtains, vents and air condition units are functioning, and that the rooms are free from odor Any issues found will be corrected by 8/24/22.	8/24/22

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F 584	Continued From page 19 room #420, #428, #502, #516, and #524, five (5) of 76 resident's rooms surveyed. 4. PTAC units did not function as intended and failed to reach set temperatures in three (3) of 76 resident rooms (#209, #508 and #524). During a face-to-face interview on 04/04/22, at approximately 4:00 PM, these findings were acknowledged by Employee #16 (Maintenance Director) and Employee #17 (Environmental Services Director).	F 584	MONITORING CORRECTIVE ACTIONS: Director of Maintenance and Housekeeping director will validate that all privacy curtains, bathroom vents, air condition units are functioning properly and that the rooms are free from odor weekly x4 then monthly x3. Any issues found will be corrected and reported to QAPI committee.	8/24/22
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, for seven (7) of 105 sampled residents, facility staff failed to ensure residents were free from abuse (willful infliction of injury) and neglect as evidenced by: failure to prevent	F 600		

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F 600	Continued From page 20 the willful infliction of serious injury of Resident #404 by Resident #82; failure to implement person center care measures for Resident #151 who had incidences of aggressive behavior towards Resident #71 and willful infliction of injury to Resident #67; failure to ensure staff received training to provide person-centered care to Resident #409 post hip replacement, subsequently the resident sustained a dislocated hip; failure to ensure Resident #3's airway (stoma) was not occluded by a medical device Heat Moisture Exchanger (HME) subsequently, the resident to be transferred to the Emergency Room (ER) for dislodgment; and failure to have available lary-tube and HME (medical equipment) for treatment and care of Resident #3's stoma subsequently, the resident was transferred to the ER a second time for replacement of the Lary-tube. Actual harm was determined to be present for Residents #404, #71, #67, #409, and #3. The findings include: Review of the facility policy entitled, "Prohibition of Abuse" [not dated], documented, "Abuse is the willful infliction of injury ... resulting in physical harm, pain or mental anguish ... Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ... Neglect, is failure of the facility, 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..." Review the facility policy entitled,	F 600	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #404 expired in the hospital; this deficiency cannot be retroactively corrected. Resident #82 was assessed from head to toe on 4/26//22 by Clinical Care coordinator, resident suffered no negative outcomes. MD/RP notified on 4/26/22. Resident's aggressive behavior was addressed; he was on 1;1 monitoring until evaluated by psych doctor. Resident was placed in a private room on 2/22/22 and on 1:1 continuous monitoring. Resident taken into custody by DC police department on 7/20/22, currently no residing at the facility. Resident #3 was discharged home from the facility 3/29/22 Resident #67 was assessed head to toe by Clinical Care Coordinator on 4/26/2022 for bruises, redness and pain. Resident denied pain. Resident suffered no negative outcomes. MD/RP notified on 4/26/22. Resident #71 was assessed from head to toe by Clinical care coordinator on 4/26/2022 . Resident will be monitored by staff for aggressive behavior every shift. MD/RP notified on 4/26/22. Resident #151 was assessed from head to toe on 4/26/2022 Unit Manager, resident did not suffer any negative outcome.MD/RP/ notified on 4/26/22. Resident is on continuous 1;1 monitoring for aggressive behavior every shift with reevaluation by the psych doctor until further notice.	8/24/22

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F 600	Continued From page 21 "Resident-to-Resident Altercation/Incidents" revised on 01/2022 documented, " ... When a resident is observed or identified as being aggressive to having aggressive behavior or has the potential for abusing other residents, an assessment of strategies to prevent such incidents from occurring will be provided by the Interdisciplinary Team (IDT)..." Review the facility policy entitled, "Your Rights and Protections as a Nursing Home Resident" revised on 03/2022 documented,"...You have the right to be free from verbal, sexual, physical, and mental abuse..." 1. Facility staff failed to prevent the willful infliction of serious injury of Resident #404 by Resident #82 evidenced by failure to adjust Resident #404's plan of care resulting in a resident-to-resident altercation. Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, " ...The charge nurse observed [Resident 404] sitting on the floor besides his roommate's ... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..." Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's	F 600	F 600 Resident #409 was discharged to another facility 9/28/21. All residents with stoma sites will be assessed and any issues will be addressed by 8/24/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Residents with behavior problems and those with stoma to aide in respiration have the potential to be affected. House wide audit will be conducted by Clinical care Coordinator, Unit Managers / Designee to ensure that residents have been assessed for aggressive behavior with the potential to abuse others, that care plans for residents with behavior issues clearly indicate the kind of behavior the resident is exhibiting, that residents with behavior have adequate supervision, and that staff members are fully trained on how to care for residents with aggressive behavior. Any issues found will be addressed by 8/24/2022. Residents with wandering behavior will be redirected, supervised, and monitored every shift by charge nurses and C N A’S	8/25/22

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F 600	Continued From page 22 Name] ... in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..." Review of a Complaint dated 03/31/22 documented, "...Avoidable death. Comments: Patient assaulted in nursing home. Beneficiary was assaulted 02/22/2022 in skilled nursing facility by another resident. He sustained blunt head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died ..." Resident Background Information: A. Resident #82 was admitted to the facility on 09/15/21with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss. Resident #82's Quarterly Minimum Data Set (MDS) dated 01/31/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating intact cognitive response, no physical or behavior symptoms directed towards others, required supervision with one person physical assist for activities of daily living (ADLs), used a walker for mobility and received antipsychotic medications. B. Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack. Review of Resident #404's medical record	F 600	F600 MEASURES TO PREVENT RECURRENCE: In-service will be provided by Staff educator/ designee to all Licensed Nursing staff on the importance to ensure that residents with behavior have a person-centered care plan that clearly state the type of behavior they are exhibiting and that they are provided supervision during their shift by 8/25/2022. Repeat in-service will be provided as needed. Training will be provided by Staff Educator/ Designee to all licensed nursing staff on the importance of creating a person -centered care plan for all the residents based on their diagnosis . Training will be provided by Staff Educator/Designee to all licensed nursing staff on stoma care and the importance of creating a person-centered care plan for the residents to reflect their diagnosis , especially for residents with hip replacements by 8/24/2022. Repeat in-service will be provided as needed. Charge nurses will ensure that residents with aggressive behavior are supervised and monitored during their shifts, and that there is documentation in place. Any issues found will be corrected by 8/24/22. In service will be provided by rehab director to all licensed nurses on how to assess residents with hip replacement and to C N A 's on how to assist residents with Hip replacement by 8/24/2022. In-service will also be provided by staff educator / Designee to all nursing staff on now to carry out CPR on a resident with a stoma by 8/24/2022	8/24/22

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F 600	Continued From page 23 revealed the following: 12/16/21 [Quarterly MDS] showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment. In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily" In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion In Section P (Restraints and Alarms), wander/elopement alarm, "Used daily" Care Plan: 07/27/21 (Revision date) "[Resident #404] is at risk for Elopement: cognitive impairment, dementia ... Observed wondering at the adjacent unit on 5/28/2021. Wandering to the adjacent unit on 7/3/21. Redirected easily. Wandering to the adjacent unit on 6/8/2021. Easily redirected. Wondering on 7/11/2021. Redirected. Wondering to the adjacent unit 7/27/2021, Easily redirected ... Avoid leaving unattended or unobserved for long periods of time. Hourly elopement/wandering monitoring and location." Review of the Daily Behavior Documentation	F 600	Charge nurses will ensure that residents with stoma site and on a respiratory equipment are assessed every shift and ensure documentation is in place. Equipment must be clean by respiratory therapist/ licensed nurses weekly. Any issues found will be corrected by 8/2422 ADON/Designee will ensure that residents requiring one on one staff monitoring secondary to intrusive and aggressive behavior, are placed on 1:1 until evaluated by psychiatrist/Designee. Any issues found will be corrected by 8/24/22. Supervisors will conduct rounds during their shift to ensure that resident with aggressive behavior are monitored and adequate supervision is provided. Updates provided during validation meeting. Any issues found will be corrected by 8/24/22. Unit Managers will audit charts to ensure that residents on their unit have person centered care plan based on their diagnosis. Any issues found will be corrected by 8/24/22 Unit managers/supervisors will ensure that residents with hip replacement are assessed daily to ensure care plan implementations are being followed. Supervisors will be notified about residents condition during validation meeting daily. Any issues found will be corrected by 8/24/22 In service will be provided by staff educator / Designee to all restorative aides , C N A's and licensed nurses on how to assist resident with hip replacements by 8/24/2022.	8/24/22

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F 600	Continued From page 24 showed the following: 02/02/22 at 2:12 PM "... Elopement attempts. Wandering ....sleeping in other people's bed... Behaviors are constant." 02/03/22 at 1:12 PM "... sleeping in other people bed. Behaviors are constant." 02/07/22 at 1:52 PM "... sleeping in other people's bed. Behaviors are constant." 02/09/22 at 1:47 PM "...sleeping in other peoples bed. Behaviors are constant." 02/10/22 at 12:17 PM "...sleeping in other peoples bed...Behaviors are constant." 02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant." 02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant." 02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant." 02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant." 02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant." 02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant."	F 600	Unit mangers will audit charts to ensure that care plans are updated/ revised for all residents monthly. Findings will be corrected by 8/24/22. Facility administrator/ Designee will ensure that respiratory medical equipment's are in current supply every week. Findings will be corrected immediately until 8/24/22. Training will be provided by staff educator/ designee to all Licensed Respiratory therapist on the importance of documenting after assessing a resident especially abnormal findings and indicate what immediate actions were taken to resolve the issue. Findings will be corrected by 8/24/22. Unit manager will ensure that charge nurses are documenting on all residents during their shift and that the documentation reflects the residents' condition weekly. Findings will be corrected by 8/24/22. Unit managers will ensure weekly that incident reports are completed and that the names and room numbers of all parties involved are indicated. Findings will be corrected by 8/24/22 Resident #67 is not on the same unit as resident #71 Unit manager will ensure any resident with hip replacement has a person centered care plan by 8/24/22	8/24/22

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F 600	Continued From page 25 Skin Observation Tool dated 02/21/22 at 2:40 AM documented, "Observations... face... Blood was coming from his mouth, we managed to stop it by applying cold compress and ice..." Situation Background Assessment Request (SBAR) dated 02/21/22 at 4:00 AM showed, "Situation... The resident got hit by his roommate... Background: Altered mental status... Resident Reports Pain? 'No'. Non-verbal indicators of pain evident? 'No'. Functional Status unchanged... Skin/Wound Status- (area was left blank) ... Assessment ... (area was left blank) ... Additional comments ... At approximately 02:30 am ... The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face. The writer immediately notify the supervisor and called 911. DC (District of Columbia) police. I saw [Resident #82] also sitting on his walker facing [Resident #404]. The writer asked [Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware." 02/21/22 at 4:16 AM [Nursing Supervisor Progress Note] "The Charge Nurse reported that While making routine rounds, Resident [#404] was observed sitting on the floor beside Room 420 A. Resident was noted with some blood on the left side of his face, a quick assessment was made, he was assessed for pain and discomfort. Resident could not describe what happened. This is his base line. A quick assessment was done, Range of motion exercise was done, ice was	F 600	For other residents with the potential to be affected by aggressive behavior of other residents, education will be provided to those with BIMS of 12 and above to report anyone that is approaching them aggressively to the nurses or CNA's by 8/25/2022. For residents with low BIMS score, rounds will be made every two hours by employees working on the unit, to ensure no one is exhibiting an aggressive behavior towards them. Any issues found will be addressed by 8/25/22. Education will be provided by staff educator to C N A'S, housekeeping staff, unit secretaries, environmental staff on care plan interventions for residents with aggressive and wandering behaviors, MONITORING CORRECTIVE ACTION: DON/Designee will conduct weekly rounds and audit charts of residents with behavior problems to ensure that they have a resident centered care plan that reflects their behavior and that they are adequately supervised every shift. DON/Designee will also conduct weekly rounds to validate that resident with stoma sites are monitored every shift and that they are in no form of respiratory distress. Rounds /audit will be conducted weekly x4 then monthly x3. Findings will be corrected immediately and reported to QAPI committee.	8/25/22

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applied to the left side of the face, vital signs was monitored T. (temperature) 96.5, P. (pulse) 82, R. (respirations) 18, B.P. (blood pressure) 140/90, Spoe (sp) (oxygen saturation) 97% on Room Air."

02/21/22 at 1:43 PM [Nurses Note] "A call was placed to [Hospital Name] to know about the status of the resident [#404] in the ER, spoke with nurse [Registered Nurse's Name] who stated Resident (#404) is critically ill, he has been intubated and about to be transferred to ICU (intensive care unit). RP ... made aware."

During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, " ... Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D [Resident #404] Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed ..."

Review of this evidence showed that facility staff had knowledge of and documented Resident #404's intrusive behavior of going into other resident's rooms and sleeping in other resident's beds.

a. Although the facility had a care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revised to address the residents intrusive behavior (wandering into other resident rooms and sleeping in their beds).

b. Facility staff failed to document the names, room numbers of residents who were affected by Resident #404's behavior; and failed to assess

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how Resident #404's behavior impacted other residents such as putting himself or others at risk for physical injury, intrusion on their privacy or activity, upset that he in their room and sleeping in their bed.

c. Although the staff record that Resident #404 was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that monitoring the resident was readjusted to manage the residents behavior.

During a face-to-face interview conducted on 04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) stated, "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make updates as needed." When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in other resident's beds, Employee #7 stated, "I was never made aware by the nurses on the unit. I knew him [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation ..." that stated Resident #404's behavior, Employee #7 stated, "I didn't see it."

2. Facility staff failed to provide adequate supervision and implement the plan of care interventions for Resident #151 to protect and prevent Residents #71 and #67 from incidences of aggressive behavior (resident-to-resident

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altercations) and willful infliction on injury.

Review of Facility Reported Incidences showed the following altercations involving Resident #151:

Review of the FRI dated 12/09/21 documented, " ... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Review of the FRI dated 01/02/22 documented, " ...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby ..."

Resident Background Information for Residents'

A.Resident #151 was admitted to the facility on 10/22/20 with multiple diagnoses that included: Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia.

Review of Resident #151's medical record revealed:

12/08/21 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe cognitive impairment.

In Section E (Behavior):

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - "Behavior of

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this type occurred 1 to 3 days", verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - "Behavior of this type occurred 4 to 6 days", Impact on Resident ... Put the resident at significant risk for physical illness or injury? "yes"; impact on others ... put others at significant risk of physical injury? "yes"; significantly intrude on the privacy or activity of others? "yes"; significantly disrupt care or living environment? "yes"

In Section G (Functional Status): Activities of Daily Living (ADL) Assistance - bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, Resident #151 required "supervision" and "one person physical assist"

Review of the Care Plan revealed:

07/27/21 (Revision date) "As evidenced by a positive PASARR (Preadmission Screening and Resident Review) Level I screen and Level II evaluation, it was determined that the resident needs Specialized Services while in the Nursing Facility. Related to: schizophrenia ...Inform the MD (medical doctor) if the Individual has a serious health decline and services previously agreed to may need to be modified or deleted. Inform the MD of any significant changes may require additional evaluation to add, modify or remove services ..."

07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..."

10/18/21 (Revision date) "[Resident #151] has problematic manner in which resident acts

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characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with taking medications, non compliant with vital signs, non compliant with shaving and showers. Non compliant with Wader guard placement kicking and hitting ..."

10/20/21 (Revision date) "[Resident #151] has impaired cognitive function or impaired thought processes r/t (related to) Dementia..."

10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..."

10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..."

B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension.
Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21where facility staff coded a BIMS summary score of "09", indicating moderate cognitive impairment, no potential

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indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions.

C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance.

Review of Resident #67's medical revealed, a Quarterly MDS dated 11/06/21 where facility staff coded a BIMS summary score of "14", indicating intact cognitive response, no potential indicators of psychosis, no physical or verbal behavioral symptoms, limited to extensive assistance with one person physical assist for ADLs and no limitations in range of motion.

Altercation #1 involving Residents #151 and #71:

12/08/21 at 11:18 AM [Nurses Note] " ... At 0730AM, the [Security Officer's Name] and the [Receptionist's Name] observed resident [#151] assaulting another resident [Resident #71] at the front of the building. The security officer and the receptionist ran to the residents and separated both residents... [Resident #71] was interviewed. He said, 'the man jumped on me in front of the building for no reason. I have never spoken to him. I don't know where this came from today' ... asked [Resident #151] why he assaulted [Resident #71]. He said, 'he raped my daughter' ... The MPD (Metropolitan Police Department) was called ... took [Resident #151] because of his aggressive behavior and transported him to [Hospital Name] at 0809 (AM) for evaluation. [Resident #71] was assessed and small scratch

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mark observed on the back of his left hand..."

Altercation #2 involving Residents #151 and #67:

12/30/21 at 11:30 AM [Nurses Note] " ... At 2030 (8:30 PM) on 12/29/2 (12/29/21).., Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby; the receptionist notified the supervisor; the supervisor assessed [Resident #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45 PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site. No swelling, discoloration or open area observed during assessment. He denied pain ..."

Review of Resident #151's medical record showed documented aggressive behaviors and a resident-to-resident altercation on 12/08/21. There was no documented evidence that facility staff revised Resident #151's plan of care to protect other residents; and then on 12/29/21, Resident #151 attacked another resident at the facility. In both instances the resident was removed from the facility due to his aggressive behaviors towards other residents.

During a face-to-face interview conducted on 04/14/22, Employee #7 (Clinical Coordinator)

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acknowledged the findings and stated that Resident #151 has been on 1:1 since he was admitted back to the facility in 01/2022 and has not had any resident-to-resident altercations.

3. Facility staff failed to ensure staff received training to provide person centered care (related to hip precautions) for Resident #409 after she had left hip surgery.

Review of an intake form for a complaint received by the State agency on 12/06/21 documented " ...after having hip surgery on 07/08/21, was observed two days later on 07/10/21 with "leg positioned like the letter 'K'...." Resident #409 was sent to the hospital for a dislocated hip and hip surgery.

Resident #409 was admitted to the facility on 07/08/21 with diagnoses that included: Encounter for Orthopedic Aftercare, Presence of Left Artificial Hip Joint, Alzheimer's Disease (Unspecified), Repeated Falls, Muscle Weakness (Generalized), and Other Abnormalities of Gait and Mobility.

Review of Resident #409's medical record revealed the following:

A Quarterly Minimum Data Set (MDS) for Resident #409 dated 07/11/21 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating severe impaired cognition.

In Section G (Functional Status), ADL assistance:

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for transfers, toilet use, and personal hygiene, the resident was totally dependent and required two or more person's physical assistance from two or more staff. For bed mobility, the resident required limited physical assistance from one staff member. For dressing, the resident required extensive physical assistance from one staff member.

In Section H (Bowel and Bladder) - "Always incontinent" for bladder and bowel

In Section J (Health Conditions), "Yes" to: resident have a fall any time in the last month prior to admission /entry or reentry; resident have fracture related to a fall in the last 6 months prior to admission /entry or reentry; resident have major surgery during the 100 days prior to admission; resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay.

In Section O (Special Treatments, Procedures, and Programs), start date for Occupational and Physical Therapy "07/09/2021."

07/08/21 at 12:10 PM [Hospital Discharge Summary] "...Hospital Course Patient presented with left hip fracture; status post Arthroplasty (hip replacement). With no postoperative complications ...Discharge Procedure Orders ...Weight Bearing as Tolerated (WBAT); Laterally; Left ...Restrictions as follows: Posterior hip precautions..."

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with

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pillow and WBAT. Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach ..."

07/08/21 (3:00 PM-11:00 PM) [CNA Documentation], facility staff documented that Resident #409 was given a bath, assisted with bed mobility and provided incontinent care for bowel and bladder.

07/09/21 [Physician's Order] "Left hip: monitor left hip for inflammation, pain, and drainage."

07/09/21 at 2:18 PM [Physical Therapy Evaluation and Plan of Treatment Note] " ...referred to skilled therapy after having a L (left) hip hemiarthroplasty that resulted from a fall... Precautions ... (no flexion past 90 degrees, abduction past midline, or internal rotation, WBAT ..."

07/09/21 (7:00 AM-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing, assistance with bed mobility, and provided incontinent care for bowel and bladder.

07/09/21 (3:00 PM - 11:00 PM) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed mobility, and provided incontinent care for bowel and bladder.

07/09/21 (11:00 PM-7:00 AM) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed mobility, and provided incontinent care for bowel and bladder.

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07/10/21 [Physician's Order] "Place a pillow between lower extremities after care, turn and reposition when resident is in bed."

07/10/21 [Physician's Order] "Wedge resident appropriately after care, turn and reposition when [the] resident is in bed."

07/10/21 (7:00 AM-3:00 PM) [Treatment Administration Record (TAR)], showed that facility staff documented that they placed a pillow between Resident #409's lower extremities after care, and wedged resident appropriately turning and repositioning when the resident was in bed.

07/10/21 (7:00-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing and bed mobility.

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain..."

07/10/21 at 5:40 PM [SBAR] "...Resident transfer to [Hospital Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She [Representative] requested her mom to be transfer[ed] to the Hospital ..."

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07/10/21 at 6:20 PM [Nurses Note] "...Family was at bedside visiting today from 11:45 AM Resident was seen by the medical director at 12:30 PM, ... At about 4 PM daughter requested that she (Resident #409) needed an X-ray to be done because she want[ed] to make sure her mothers' leg was not dislocated. Writer explains[ed] to the daughter that [the] resident has been seen by the doctor in her present (sp) just a few hours ago. If there was any concern note[d] the doctor would have order[ed] an X-ray. She insisted that she want[ed] her mom to be sent to the hospital immediately because she need[ed] an X-ray to be done and read right [away]. Writer told her that an X-ray can be gotten from the doctor, but it will take b/n (between) 2-4 hours for the X-ray to be done ...[Physician's Name] was notified and the doctor said an X-ray will take about 4-6 hours to be done so the resident should be transfer[red] to the hospital via non-emergency transport for further evaluation per family request ...Resident was taken out from the facility at 5:50 [PM] to [Hospital Name]."

07/12/21 at 6:34 PM [Hospital Discharge Summary] "The patient presents from [Name of Facility], where she has been staying for the past few days ... Her daughter and son-in-law went to visit her ... looked under her covers, and found that her left leg was significantly inwardly rotated. They were concerned something is going wrong with the surgery at the left hip, and they requested transportation to the hospital .... ED (Emergency Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced (a procedure for treating a hip dislocation without surgery) ...tolerated the procedure well ...Narratives: 02:27 PM... plan to discharge back

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to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..."

A review of the Resident #409's medical record lacked documented evidence that the facility staff that cared for Resident #409 from 07/08/21 to 07/10/21, provided her with adequate supervision, assistance and hip precautions to ensure that Resident #490's hip was not dislocated.

During a telephone interview conducted on 04/14/22, at approximately 12:30 PM, Resident #409's daughter/representative stated, "On 07/10/21, I noticed that my mother looked out of it and flinched when I pulled back the cover to see what was wrong. I didn't see the knee immobilizer on her leg. Her leg was positioned like the letter 'K'. I spoke with the unit manager and told her I wanted to see the doctor. They finally brought in the doctor, who said he wasn't my mother's primary doctor, and he ordered oxycodone for pain. I insisted that my mother get an X-ray for her hip. I was told the X-ray would take a long time (4-6 hours), so I asked the nurse to call 911. She told me she did not have a doctor's order, and I can call 911, so I did. 911 showed up and said it wasn't a medical emergency, so they [911] called a non-emergency vehicle, and my mother was transported to [Hospital Name]."

During a face-to-face interview on 04/19/22, at approximately 3:30 PM, Employee #4 (Educator) stated, "I told the daughter how long it would take (x-ray). She insisted we call 911 to have [Resident #409's] hip X-rayed and evaluated at the hospital. Per the daughter's request, with the doctor's permission, a non-emergency ambulance was called. The resident [was

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transferred out to [Hospital Name]. I did an SBAR of the incident."

During a face-to-face interview on 04/19/22 at approximately 4:00 PM, Employee #8 (2nd Floor Unit Manager) stated that training for residents with hip precautions usually occurs with physical therapy or by the unit managers when the resident is admitted. For [Resident #409], Employee #8 stated, "I did the impromptu training in the resident's room. I trained the 2-3 CNAs and two (2) nurses who worked the day and evening shifts on this unit. I reviewed how to put the pillow/wedge between the resident's legs, how to put the hip immobilizer on the resident, and how to roll the resident on her side to prevent her from crossing midline. I reminded staff to keep the bed in the lowest position and keep the call light near the resident." Employee #8 was not able to provide a copy of the "impromptu training" sign in sheet or the handouts that he said were provided to the staff.

There was no evidence that facility staff provided the necessary staff training and staff supervision to meet Resident #409's needs status post hip surgery.

4. The facility's staff failed to ensure Resident #3's airway (stoma) was not occluded by a medical device Heat Moisture Exchanger (HME) subsequently, causing the resident to be transferred to the Emergency Room (ER) for dislodgment, keep a supply of respiratory medical equipment in the facility that was necessary to care for and treat Resident #3's laryngectomy and stoma subsequently, the resident had to be transferred to the ER for a replacement; and obtain/provide Resident #3's with HMEs.

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These failures resulted in actual harm to Resident #3.

4A.Review of a complaint received by the DC Department of Health on 01/26/22 from the resident's family member alleged that Resident #3 was rushed to the ER on 12/03/21, "which could have been fatal ...because there was an HME put into his (Resident #3) neck stoma (airway)."

According to Johns Hopkins Medicine, HME is a humidifying filter that fits onto the end of the trach tube and comes in several shapes and sizes. Also known by several other terms including: Thermal Humidifying Filters, Swedish nose, Artificial nose, Filter, Thermovent T. https://www.hopkinsmedicine.org/tracheostomy/resources/glossary.html#Tracheotomy

Resident #3 was admitted to the facility on 12/01/2021 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. The resident was discharged to the hospital on 03/29/2022.

Review of an Admission Minimum Data Set dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank. Additionally, the resident was coded for receiving Tracheostomy care and speech therapy services. Continued review showed that Resident #3 was not coded for receiving respiratory therapy services.

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

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F 600	Continued From page 41 12/01/21 at 19:54 [admission nursing progress note]- Resident underwent awake tracheostomy with direct laryngoscopy and biopsy on 10/27/27 ...upon assessment, resident alert and oriented to person and place. ...Resident has a lary tube with cap [HME] in place ... 12/01/21 at 20:29 [physician assistant physician progress note]- Pt. (patient) seen at bedside appears alert and stable ...Pt. also has tracheostomy and doing well ...vitals: 126/81 (blood pressure), 86 (pulse, 18 (respiration), 97.6 (temperature), 95% RA (oxygen saturation rate on room air) ... 12/02/21 [physician order]- Change HME daily day shift. 12/02/21 at 13:15 [respiratory therapy assessment]- Type- initial assessment, Resident was alert and oriented with lary tube and holder in place with an HME. Lary tube cleaned, tube holder changed. HME changed. Pre-treatment assessment respiratory rate 18, SPO2 98% [on] room air, lung sounds clear ... Post-treatment assessment respiratory rate 18, SPO2 (peripheral capillary oxygen saturation) 99% on room air, lung sounds clear... 12/03/21 [physician order] - transfer resident to the nearest ER (emergency room) for further evaluation related to stuck HME in stoma. 12/03/21 at 14:42 [nursing progress note] - The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident	F 600		8/24/22

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denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma (airway) was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME initially stuck down in stoma (airway) and the resident coughed it up ...Resident's daughter ...called and spoke with Respiratory Therapist ...wanted to find out if resident was alive, in distress or pain and asked ...how she determine that since resident is non-verbal ... 911 called at 1345 and they arrived at 1400 ... v/s (vital signs): 121/80 (blood pressure), 63 (pulse), 18 (respirations), 97.8 (temperature), O2 Sat (saturation) 99% RA (room air).

12/04/21 [hospital discharge summary]- Diagnosis-tracheostomy malfunction. Diagnostic radiology XR (xray) neck soft tissue, XR chest PA (posterior-anterior) and LAT (lateral) 2 view. Call for follow-up appointment with physician within 2 to 4 days [provided education tool] for "How to Clean a Tracheostomy Tube, Adult."

12/04/21 at 07:54 [nursing progress note] - Resident came back from the hospital ...on arrival 129/89 (blood pressure), 18 (respiratory rate) 98% (oxygen saturation rate) on room air.

12/04/21 [physician order] - Do not occlude stoma in neck. The [patient] is an obligate neck

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breather.

12/06/21 at 16:13 [physician assistant progress note] - Re-admission follow-up, pt (patient) was hospitalized for tracheostomy malfunction. Pt. seen at the bedside appears alert and stable ...vitals: 130/67 (blood pressure), 71 (pulse), 17 (respirations), 97% RA (oxygen saturation rate on room air) ...resp (respiration): lung CTA (Clear to auscultate),BL (bilaterally).

However, further review of progress notes lacked documented evidence that the Employee #31 (Respiratory Therapist) assessed or provided care for Resident #3 from 12/03/21 to 12/06/21 (post being sent to the emergency room).

Review of the December 2021 Treatment Administration Record showed the following: Change HME daily day shift (start date 12/03/21). The facility's nurse initialed on 12/03/21 indicating that she changed Resident #3's HME on dayshift

Review of the comprehensive care plan with an initial date of 12/04/21 showed the following:
Focus Area-[resident's name] has lary tube r/t (related to) laryngeal cancer.
Goal-[resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date.
Interventions- lari-tube care daily, change HME daily, assist with cough as needed...

Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22.

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Review of a complaint received by the DC Department of Health on 01/26/22 from alleged that Resident #3 was rushed to the ER on 12/03/21, because there was an HME put into his (Resident #3) neck stoma (airway)."

Resident #3 was unable to be interviewed at the time of the survey because he was discharged to the hospital on 03/29/2022.

During a telephone interview on 04/12/22 at 11:35 AM, the resident's responsible party (granddaughter) stated that the clinical coordinator and the respiratory therapist called her informing her that the HME was stuck in her grandfather's stoma. When asked if they informed her that happened, she said, "No, neither one of them could explain, but [name of clinical coordinator] said sometimes there are things that happened that we can't explain."

During a face-to-face interview on 04/12/22 at approximately 5:00 PM, Employee #32 (LPN) stated, I cleaned something in his neck two times a shift. Respiratory sees him (Resident #3) all the time. I had training from respiratory, but I don't remember when." The employee also said , "I don't remember the resident (Resident #3) using a HME."

During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated that when the respiratory therapist informed him that an HME was stuck in the resident's stoma (airway), he had Resident #3 transferred to the emergency room for evaluation. The employee then said that Resident #3 was not any distress when the HME was lodged his stoma

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(airway) When asked if an investigation was conducted to determine how the incident of the HME being lodged in Resident #3's stoma (airway) happened? Employee #7 stated, "No." The employee also said the respiratory therapist was responsible for changing the resident's HME.

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that she informed the staff that Resident #3's HME was "stuck in his stoma (airway). I'm not sure how the HME got stuck in his stoma. If he (Resident #3) did not get the HME out of his stoma it would have been detrimental." The employee stated that she worked three to four days a week, and on the days, she was not in the facility nursing staff was responsible for cleaning Resident #3's lary-tube and changing the HME. Also, Employee #31 said that she provided nursing staff education on how to care for Resident #3's lary-tube and HME and documented the training on a clipboard in her office. The employee also said she required nursing staff to do a return demonstration to ensure competency.

During a face-to-face interview on 04/14/22 at approximately 3:00 PM, Employee #33 (RN) stated that respiratory therapy provided her with training on tracheostomy care, but they did not they did not provide education on laryngectomy's, lary-tubes, or HMEs. The employee said that although she regularly worked on the floor were Resident #3 resided, she could not remember working with him.

A eview of in-service training documents lacked documented evidence that staff was provided education on the lary-tubes or HMEs.

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During a face-to-face interview on 04/14/22 at approximately 3:30 PM, Employee #4 (Educator) stated that the respiratory therapist was responsible for providing staff education on the lary tube and HME. The employee said that the respiratory therapist was to provide her with written documentation of education provided to staff. However, she said, "I don't have any records of education provided by the respiratory therapist."

There was no evidence that facility staff developed a person-centered approach to care and implemented measures necessary to provide care to Resident #3 who had a laryngectomy. Subsequently, Resident #3's airway (stoma) was occluded by a medical device HME, causing him to be transferred to the ER for dislodgment of the device.

4B.Review of an intake form for a complaint received by the DC Department of Health on 01/26/22 showed the complainant [granddaugter] alleged that Resident #3 was sent to to the ER on 01/07/22 for a "lary tube replacement due to facility throwing out the one (lary-tube) he had."

According to the University of Arkansas for Medical Science, a lary tube is a flexible silicone tube designed to maintain the stoma right after the laryngectomy surgery. A lary tube is used to maintain the airway and can be following a laryngectomy.
https://patientslearn.uams.edu/wp-content/uploads/sites/95/2018/03/Lary_Tube_Care.pdf

Review of Employee #31's (Respiratory Therapist) signed and dated 06/03/19 job

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description, showed that she was responsible for providing necessary material and equipment for resident (sp) to perform required therapy.

Resident #3 was admitted to the facility on 12/01/2021 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status.

Review of an Admission MDS assessment dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank, indicating the resident was not assessed.

Additionally, the resident was coded for receiving Tracheostomy care and speech therapy services.

Review of the resident's medical record revealed a physician's order dated 12/02/21that stated, "Cleanse Lari-tube daily on day shift."

Further review of the resident's medical record revealed the following:

-01/07/22 at 4:51 PM: "It was observed today that resident Laryn [lary] tube is out. He was assessed by the respiratory therapist and recommended to send resident out to the ER for laryn [lary] tube replacement. 911 arrived ...left at 4:40 PM. "

-01/07/22 at 6:10 PM: "[MD's Name] called from [Name of Hospital] need to know the size laryngectomy tube. RT (respiratory therapy) note said size was gathered at admission."

-01/08/22 at 6:32 AM: "Resident returned from [Name of Hospital] at 2:30 AM in stable condition

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F 600	Continued From page 48 ... O2 SAT (oxygen saturation) 95% RA (room air)."; and -01/08/22 at 4:02 PM: "Resident alert and oriented...Resident observed with difficult breathing with the new lary tube placed from hospital 1/7/22. Resident's family took him to [Name of Hospital] for follow-up and possible change of lary tube...resident ... O2 sat (oxygen saturation) 98." Review of the comprehensive care plan with an initial date of 12/04/21 showed the following: Focus Area-[resident's name] has lary tube r/t (related to) laryngeal cancer, 01/07/22 sent out for laryn (sp) tube placement, taken to ER for laryn (sp) tube replacement. Goal-[resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed... Review of respiratory therapy assessment/infection screener progress notes lacked documented evidence the respiratory therapist assessed or provided care for Resident #3 from 01/05/22 to 01/12/22. Review of complaint #DC00010525 showed the complaintant alleged that Resident #3 was sent to the ER on 01/07/22 for a lary tube replacement due to facility throwing out the one (lary-tube) the resdient had. During a telephone interview on 04/12/22 at 11:35 AM, the resident's granddaughter stated that the facility made her aware of the lary-tube missing.	F 600		8/24/22

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The resident's granddaughter said, "I told them that my grandfather's lary tube was missing when I visited him 5 days prior. I asked them why it took them so long to get his lary-tube replaced."

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that when the resident's lary tube was misplaced (01/07/22) she had the resident sent out the ER for replacement. The employee then reported that while Resident #3 was in the emergency room the emergency room staff called her to inquire about the size of the resident's lary-tube, but she could not give the physician the size because she did not know the size of the resident's lary- tube. When asked if it was her responsibility to order respiratory supplies, Employee #31 said, "Yes" but she could not order Resident #3's lary-tube because she "did not know the size." When asked if she made the resident's physician or medical director aware, the employee stated, "No, I don't talk the doctors. I made [Administrator's name] and [Clinical Director's name] aware several times.

Through interview with Employee #31 there was no evidence that facility staff knew the size of Resident #3's Lary Tube to order replacements, therefore, no were available in the facility for use. Subsequently, Resident #3 was sent to the emergency room for replacement of the lary tube.

4C. Facility staff failed to obtain/provide Resident #3 with HMEs that were necessary to help reduce mucus production and coughing by humidifying and filtering the air breathed through his stoma from 01/08/22 to 03/02/22.

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According to Oxford University Hospital, it is important to keep your mucus thin so that it is easy to cough up [mucous]. You should always wear a stoma protector such as a ...Heat Moisture Exchange (HME: baseplate and cassette). These are available on prescription and will moisten mucous ... https://www.ouh.nhs.uk/patient-guide/leaflets/files/11587Pstoma.pdf

Review of complaint #DC00010525 revealed allegations that the facility did not have lary-tubes and HMEs for Resident #3.

Review of Resident #3's medical record showed the following Physician's orders:

12/02/21 [Physician's Order] "Change HME daily Day shift."

12/02/21 [Physician's Order] "Change Lari-Tube daily Day shift."

The medical record also contained the following nursing notes:

01/07/22 at 4:51 PM [nursing progress note]- It was observed today that resident larynx tube is out. He was assessed by the respiratory therapist and recommended to send resident out to the ER for larynx tube replacement. 911 arrived ...left at 4:40 PM. However, review of respiratory therapy assessment / infection screener progress notes lacked documented evidence the respiratory therapist assessed or provided care for Resident #3 from 01/05/22 to 01/12/2022.

01/07/22 at 6:10 PM [nursing progress note] - [MD's Name] called from [hospital's name] need

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to know the size laryngectomy tube. RT (respiratory therapy) note said size was gathered at admission.

01/08/22 at 6:32 AM [nursing progress note] - Resident returned from HUH at 2:30 AM in stable condition ...vs (vital signs): 144/75 (blood pressure), 18 (respiration), 70 (pulse), 96.8 (temperature), O2 SAT (oxygen saturation) 95% RA (room air).

01/08/22 at 4:02 PM [nursing progress note] - Resident alert and oriented. Resident tolerated feeding and all medications. Resident observed with difficult breathing with the new lary tube placed from hospital 1/7/21. Resident's family took him to [Name of Hospital] for follow-up and possible change of lary [laryngectomy] tube ...resident ...O2 sat (oxygen saturation) 98.

Review of Treatment Administration Records from 01/08/22 to 03/02/22 showed that the facility's nurses initialed they changed Resident #3's HME daily on dayshift. However, it should be noted that per the respiratory therapist (Employee # 31) the HME could not be changed from 01/08/22 to 03/02/22 because the facility did not have HMEs compatible to connect with Resident #3's lary-tube.

Review of the comprehensive care plan with an initial date of 12/04/21 showed the following:
Focus Area-[resident's name] has lary tube r/t (related to) laryngeal cancer, 01/07/22 sent out for laryn (sp) tube placement, taken to ER for laryn (sp) tube replacement.
Goal-[resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of

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infection through the review date.
Interventions- lari-tube care daily, change HME daily, assist with cough as needed...

Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22.

Review of the of an invoice dated 03/02/22 showed the facility ordered one box of 30 cassette HMEs and 1 laryngectomy (Lary) tube. Further review of the invoice showed hand written entry "recevied [on] 03/03/22".

Review of emails from Resident #3's responsible party to Employee #11 (Social Worker) showed the following:

02/22/22 at 9:30 AM -"On February 7th and February 8th, I emailed [Employee #31's name-respiratory therapist] in reference to Resident #3's name lary-tubes and HME's being ordered. In prior conversation she (Employee #31) stated that she needed to know the size of tube so that she (Employee #31) could order his (Resident #3) supplies. I gave her the information on the 7th (02/07/22). Checked back with her the following Monday 02/14/22) and she stated she order the belonging (Lary-tubes and HMEs) ...She (Employee #31) has the information and the items (lary-tubes and HMEs) need to ordered ASAP."

03/07/22 at 12:54 PM- : Has anyone looked into his (Resident #3) lary tubes and HMEs being ordered. I gave the needed information, and he still hasn't received those supplies that [Employee

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#31's name- respiratory therapist] ordered on February 7th of 2022. She stated that she would get back with me and never did. Theses supplies are important necessities to his current state he is in."

03/25/22 at 12:47 PM -It was told to me that the HME's and lary-tubes were ordered for [Resident #3's name] back in February. Medicaid is requesting the invoices for said orders ...Can you send me any and all documentation in reference to these invoices?

During a telephone interview on 04/12/22 at 11:35 AM, the resident's emergency contact (granddaughter) stated, "He was without a lari-tube several times and they (lari-tube) had to be replaced by the treatment (chemo infusion center) center. The granddaughter then said, "I emailed [Employee #7's name -respiratory therapist] on 02/07/22 and 02/08/22 size for supplies (lari-tube, collar, and straps) but she never responded. I called her (Employee #7) a week later (02/14/22) and she said [Employee #7's name - Clinical Coordinator approved the supplies and she (Employee #7) ordered them."

During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated, "We had a problem with supplies one time, and I told the respiratory therapist (Employee #31) and she ordered them."

During a face-to-face interview on 04/14/22 at approximately 2:00 PM, Employee #11 (Social Worker) stated that Resident #3's granddaughter emailed him on 02/22/22, 03/22/22, and 03/29/22 inquiring about order for supplies (HMEs and Lary-tubes).

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During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that Resident # 3 did not a have HME to connect to his lary-tube from "01/08/22 to until they were ordered and received by the facility [03/03/22]". When asked why it took so long for Resident #3 to get the HME, Employee #31 said "I did not know the size of the resident's lary-tube. And the HMEs we had in house was not compatible with the lary-tube his family provided on 01/08/22." The employee then said she reached out to the granddaughter on 01/12/22 or 01/13/22 to get the name of the lary-tube so she could order an HME, but the granddaughter said, "The doctor told me (granddaughter) that the HME is not important", and she did not send me the size of the lary-tube until 02/07/22." Employee #31 said that she did call the resident's physician once to get the size of his lary-tube once, but he did not call her back. However, she made Employee #1 (Administrator) and Employee #7 (Clinical Coordinator) aware multiple times that Resident #3 did not have HMEs.

During a face-to-face interview on 04/20/22 at approximately 2:00 PM, Employee #44 (Admission Director) stated that newly admitted residents' medical supplies are ordered and in the facility before the resident's admission. When asked if Resident #3's lary-tubes and HME were ordered and in the facility before his admission (12/01/22), she stated, "I don't know because I was not in the facility at that the time he was admitted. It should be noted that the one (1) invoice the facility provided to the surveyor had a date of 03/02/22, which documented that the facility received one (1) lary-tube and 30 HMEs on 03/03/22.

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F 600	Continued From page 55 Review of Treatment Administration Records showed that nusing staff documented that they changed Resident #3's HME on the following dates: 01/09/22 to 01/25/22, 01/27/22 to 02/02/22, 02/04/22 to 02/08/22, 02/11/22 to 02/14/22, 02/18/22 to 02/22/22, and 02/24/22 to 03/01/22. However, it should be noted that the one (1) invoice provided by the facility with an order date of 03/02/22 showed the facility did not receive HMEs until 03/03/22, at which time they received 30. During a face-to-face interview on 04/20/22 at approximately 2:00 PM, Employee #44 (Admission Director) stated that newly admitted residents' medical supplies are ordered and in the facility before the resident's admission. When asked if Resident #3's lary-tubes and HME were ordered and in the facility before his admission (12/01/22), she stated, "I don't know because I was not in the facility at that the time he was admitted." It should be noted that the one (1) invoice the facility provided to the surveyor had a date of 03/02/22, which documented that the facility received one (1) lary-tube and 30 HMEs on 03/03/22.	F 600		8/24/22
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607		

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F 607	Continued From page 56 implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for eight (8) of 105 sampled residents, facility staff failed to implement its policies and procedures for investigating allegations of abuse, neglect and injuries of unknown source. Residents' #11, #50, #67, #71, #151, #221, #408 and #409. The findings include: Review of the facility policy entitled, "Prohibition of Abuse" (not dated), documented, " ... Reports on abuse are reviewed and investigation conducted by the director of nursing ... within 24 hours following the incident ...If suspected abuse/inappropriate behavior are between two residents, residents will be immediately separated from each other and monitored until appropriate interventions are implemented...All employees will sign a memo attesting, their understanding and compliance to abuse standards..." Review of the facility's policy also showed that neglect was defined as "the failure of the facility, 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 policy revealed that	F 607	F 607 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #11 was assessed from head to toe by Charge nurse on 4/26/22, no signs of abuse or neglect noted, no redness, swelling nor discolorations noted. MD/RP notified on 4/26/22 Resident #50 was assessed from head to toe by Charge nurse 4/26/22, no signs of abuse nor neglect noted. No swelling, redness nor discoloration noted .MD/RP notified on 4/26/22 Resident #67 was assessed from head to toe by Charge nurse on 4/26/22, no signs of abuse / neglect noted . No swellings redness nor discoloration noted.MD/RP notified on 4/26/22. Resident #71 was assessed by Unit Manager on 4/26/22 no signs of abuse/ neglect noted. No swellings, reddened area nor discoloration noted.MD/RP notified on 4/26/22 Resident #151 was assessed from head to toe by Unit Manager on 4/26/22, no signs of abuse/neglect noted. No redness , swelling nor discoloration noted. MD/RP notified 4/26/22 Resident #221 signed out of the facility against medical advice on 5/19/2021 Resident #408 was sent to the ER on 2/12/22 and did not return. Resident #409 was discharged home on 9/28/21	8/24/22

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F 607	Continued From page 57 staff are to complete an incident/accident form for any unusual occurrences and submit it to the Director of Nursing or designee ...A final report of the investigation will be reported and signed by the Administrator." Review of the facility policy entitled, "Investigation Process" dated 02/2022 showed, " ...The facility will ensure thorough investigation during an incident or occurrences that may involve our residents, employees, volunteers, and visitors ... interview and/or obtain statement from victim/resident ... interview and/or obtain statements from alleged perpetrators, interview and or obtain statements from potential witnesses ... [Facility Name] will use the following... components to eliminate and/or minimize the risk associated with resident abuse: screening, training, prevention, identification, protection, and reporting response..." 1. Facility staff failed to interview and/or obtain statements from all staff involved in Resident #11's care in an allegation of neglect. Resident #11 was admitted to the facility on 04/22/15 with diagnoses that included: Bipolar Disorder, Anxiety Disorder, Major Depressive Disorder and Convulsions. Review of Resident #11's medical record revealed: 12/17/21 [Quarterly Minimum Data Set (MDS)] where staff coded, a Brief Interview for Mental Status (BIMS) summary score of "03", indicating severe cognitive impairment, "total dependence" with "one person physical assist" for personal hygiene and "frequently incontinent" for urinary	F 607	F607 IDENTIFICATION OF RESIDENTS WITH THE POTENTIAL TO BE AFFECTED: All residents in the facility have the potential to be affected. House wide audit will be conducted by Clinical Coordinator, Unit Managers and Supervisors to ensure that policies and procedures on abuse and neglect are implemented as indicated on all the residents. That all incidents are thoroughly investigated, and that staff involved in the investigation provide statements of what occurred. Any findings will be corrected by 8/24/2022. DON/Designee will audit all incidents/ accident reports to ensure that investigations of all incidents were carried out appropriately and that statements were obtained from employees who worked on the unit were the incident took place are in order Any issues found will be corrected by 8/24/22.	8/24/22

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F 607	Continued From page 58 and bowel continence. Review of Facility Reported Incident (FRI) dated 03/18/22 showed, " ... [Resident #11's] daughter wrote a grievance on 03/14/22 stating that her father had not been changed since 03/12/22 during the night shift until 03/13/22 at 18:30 (6:30 PM). She stated that her father was soaked in urine and had feces when she came in to visit ..." Review of the facility's investigation documents provided to the writer on 04/12/22 revealed that the facility staff failed to follow its policy for investigating allegations of neglect evidenced by failure to interview and/or obtain statements from all staff that took care of Resident #11 from 11:00 PM on 03/12/22 to 11:00 PM on 03/13/22. During a face-to-face interview conducted on 04/12/22 at 2:39 PM, Employee #2 (Director of Nursing) acknowledged the finding and stated, "I was not able to get everyone's statements." 2. Facility staff failed to investigate two incidences of resident-to-resident altercations involving Residents' #71, #67 and #151. Review of the FRI dated 12/09/21 documented, "... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..." Review of the FRI dated 01/02/22 documented, " ...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby ..." Resident Background Information	F 607	F 607 MEASURES TO PREVENT RECURRENCE: In-service will be provided by Staff Educator to all staff members on the importance of providing a written statement of any incident that occur on the units by 8/24/2022. Repeat in-service will be provided as needed. Training will be provided by Staff Educator/Designee to Licensed nursing staff on how to carry out an investigation accurately by 8/24/2022. Training will be provided to RN'S and LPN' s on the importance of carrying out an investigation once an unusual occurrence occurs to find out why and how the incident occurred by 8/24/2022. Charge nurses will ensure that all nurse aides, nurses, and members of other departments provide a written statement once an incident occurs on the unit. Any issues found will be corrected by 8/24/22. ADON/Designee will ensure that every incident is thoroughly investigated upon once it occurs and that employees provide written statements. Any issues found will be addressed by 8/24/22. Supervisors will ensure that all incident reports are completed accurately and that statements are in the binder on a weekly basis. Any issues found will be corrected by 8/24/22	8/24/22

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F 607	Continued From page 59 A. Resident #151 was admitted to the facility on 10/22/20 with multiple diagnoses that included: Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia. Review of Resident #151's medical record revealed: 12/08/21 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe cognitive impairment. In Section E (Behavior): E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes" E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - "Behavior of this type occurred 1 to 3 days", verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - "Behavior of this type occurred 4 to 6 days", Impact on Resident ... Put the resident at significant risk for physical illness or injury? "yes"; impact on others ... put others at significant risk of physical injury? "yes"; significantly intrude on the privacy or activity of others? "yes"; significantly disrupt care or living environment? "yes" In Section G (Functional Status): Activities of Daily Living (ADL) Assistance - bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, Resident #151 required "supervision" and "one person physical assist"	F 607	Unit managers/ will ensure that all injuries of unknown origin are investigated and all employees who worked with the resident provide a written statement. Any findings will be corrected by 8/24/22 F607 MONITORING CORRECTIVE ACTION DON/Designee will conduct audit to validate that all incidents /accidents that occurred in the facility are fully investigated, that employees who worked the day of the incident provide written statements, that policies and procedures for abuse and neglect are followed as indicated. This audit will be done weekly x4 then monthly x3, findings will be corrected immediately and reported to QAPI Committee	8/24/22

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Review of the Care Plan revealed:

07/27/21 (Revision date) "As evidenced by a positive PASARR (Preadmission Screening and Resident Review) Level I screen and Level II evaluation, it was determined that the resident needs Specialized Services while in the Nursing Facility. Related to: schizophrenia ...Inform the MD (medical doctor) if the Individual has a serious health decline and services previously agreed to may need to be modified or deleted. Inform the MD of any significant changes may require additional evaluation to add, modify or remove services ..."

07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..."

10/18/21 (Revision date) "[Resident #151] has problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with taking medications, non compliant with vital signs, non compliant with shaving and showers. Non compliant with Wader guard placement kicking and hitting ..."

10/20/21 (Revision date) "[Resident #151] has impaired cognitive function or impaired thought processes r/t (related to) Dementia..."

10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards

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F 607	Continued From page 61 staff/others) and document per facility protocol..." 10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..." B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension. Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21where facility staff coded a BIMS summary score of "09", indicating moderate cognitive impairment, no potential indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions. C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance. Review of Resident #67's medical revealed, a Quarterly MDS dated 11/06/21 where facility staff coded a BIMS summary score of "14", indicating intact cognitive response, no potential indicators of psychosis, no physical or verbal behavioral symptoms, limited to extensive assistance with	F 607		8/24/22

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one person physical assist for ADLs and no limitations in range of motion.

Altercation #1 involving Residents #151 and #71:

12/08/21 at 11:18 AM [Nurses Note] " ... At 0730AM, the [Security Officer's Name] and the [Receptionist's Name] observed resident [#151] assaulting another resident [Resident #71] at the front of the building. The security officer and the receptionist ran to the residents and separated both residents... [Resident #71] was interviewed. He said, 'the man jumped on me in front of the building for no reason. I have never spoken to him. I don't know where this came from today' ... asked [Resident #151] why he assaulted [Resident #71]. He said, 'he raped my daughter' ... The MPD (Metropolitan Police Department) was called ... took [Resident #151] because of his aggressive behavior and transported him to [Hospital Name] at 0809 (AM) for evaluation. [Resident #71] was assessed and small scratch mark observed on the back of his left hand..."

Altercation #2 involving Residents #151 and #67:

12/30/21 at 11:30 AM [Nurses Note] " ... At 2030 (8:30 PM) on 12/29/2 (12/29/21).., Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby; the receptionist notified the supervisor; the supervisor assessed [Resident #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45

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PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site. No swelling, discoloration or open area observed during assessment. He denied pain ..."

Review of Resident #151's medical record showed documented aggressive behaviors and a resident-to-resident altercation on 12/08/21. There was no documented evidence that facility staff revised Resident #151's plan of care to protect other residents.On 12/29/21, Resident #151 attacked another resident at the facility.

During a face-to-face interview conducted on 04/14/22, Employee #7 (Clinical Coordinator) acknowledged the findings and stated that Resident #151 has been on 1:1 since he was admitted back to the facility in 01/2022 and has not had any resident-to-resident altercations.

3. Facility staff failed to implement their written policies and procedures on abuse as evidenced by failure to thoroughly investigate an alleged resident-to-resident threat of violence by Resident #221.

Review of the FRI (Facility Reported Incident) dated 03/29/22, documented " ...resident explained to the charge nurse that he did not like rooming with his roommate. He stated that if he were to continue to be in that room that one day we will find the roommate hurt ..."
Resident #221 was re-admitted to the facility on 10/28/21 with multiple diagnoses including, Cognitive Communication Deficit, Hemiplegia and

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Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Paraplegia Unspecified and Paranoid Schizophrenia.

Review of the Quarterly MDS dated 03/23/22 revealed that the facility staff coded the following: In section C (Cognitive Patterns), a BIMS Summary Score "15", indicating intact cognition.

Review of the document titled "SBAR (Situation Background Assessment Recommendation)-physician /NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool" dated 03/28/22 at 12:27 PM, showed "...Today, resident explained to the charge nurse that he did not like rooming with his roommate. He stated that if he were to continue to be in that room that one day, we will find the roommate in a pool of blood. A nurse stayed by the resident's side until the resident could be transferred to another room. Prior to being transferred to the room he was introduced to the new potential roommate and stated that the change would be fine..."

Review of the facility's incident investigation documentation that was signed and dated on 03/28/22, consisted of the following: two handwritten employee statements, a copy of a resident face sheet, a form titled "Incident/Accident report", a form titled "Quality Assurance and Performance Improvement Employee /Resident investigation report, a SBAR note, a form titled Pain evaluation for cognitively impaired & Intact.

The facilities investigative report lacked documented evidence of the following: an interview or assessment of Resident #221's

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roommate, interviews with all staff that may have knowledge of the incident, resident and staff education/training related to care approaches following the resident-to-resident incident.

During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #2 (Director of Nursing) acknowledged the findings.

4. Facility staff failed to interview and/or obtain statements from all staff involved in Resident #408's care the day an injury of unknown origin was discovered.

Review of the FRI dated 02/22/22 documented, " ...Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP (Nurse Practitioner) ... X-ray report received this morning with impression of Acute fracture of the left distal femur, Acute hairline fracture of the right lateral femoral condyle ... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident
had reported fallen to anyone ..."

Resident #408 was admitted to the facility on 05/25/2021 with multiple diagnoses that included: Hemiplegia and Hemiparesis, Hypocalcemia, Muscle Weakness and Lack of Coordination.

Review of Resident #408's medical record revealed the following:

01/04/22 [Quarterly MDS], facility staff coded the following: a BIMS summary score "04", indicating severe cognitive impairment, extensive assistance to total dependence with two plus persons physical assist" for transfers , mobility

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and personal hygiene, no impairment in range of motion.

02/16/22 at 2:27 PM [Nurse Practitioner (NP) Progress Note] "Assessment and f/u knee pain ... seen today for assessment due to c/o pain on both knees. She admits to moderate pain in her knees, dull and affecting her sleep ... Plan [x-ray] on both knees ..."

02/17/22 at 7:38 AM [Nurses Note] "Resident's X-ray of the both knees (Positive) for LT (left) knee: There is a fracture of the distal femur with displacement ... RT (right) Knee: There is irregularity and impaction and a cortical hairline fracture of the distal lateral femoral metaphysis which is impacted... A call placed to the NP ..."

02/17/22 12:05 PM [Nurses Note] " ... Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP ... NP ordered X-rays of bilateral knees. X-ray report received this morning with impression of acute fracture of the left distal femur, acute hairline fracture of the right lateral femoral condyle in normal alignment... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident had reported fallen to anyone. [Physician's Name] notified and she gave order to send resident to the ER for 2nd opinion ..."

Review of the facility's investigation documents provided to the surveyor on 04/18/22 at 10:36 AM revealed that facility staff failed to interview and/or obtain a statement from the licensed staff assigned to Resident #408 on 02/16/22 during the day shift (7:00 AM - 3:00 PM).

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During a face-to-face interview conducted on 04/18/22 at approximately 1:30 PM with Employee #43 (3rd Floor Unit Manager), she acknowledged the finding and made no further comments.

5. Facility staff failed to implement its written policies and procedures for abuse and neglect evidenced by failure to identify and investigate the unusual occurrence of Residents #409's dislocated hip.

Review of an intake form for a complaint received by the State agency on 12/06/21 documented " ...after having hip surgery on 07/08/21, was observed two days later on 07/10/21 with "leg positioned like the letter 'K'...." Resident #409 was sent to the hospital for a dislocated hip and hip surgery.

Resident #409 was admitted to the facility on 07/08/21 with diagnoses that included: Encounter for Orthopedic Aftercare, Presence of Left Artificial Hip Joint, Alzheimer's Disease (Unspecified), Repeated Falls, Muscle Weakness (Generalized), and Other Abnormalities of Gait and Mobility.

A review of the Quarterly MDS for Resident #409 dated 07/11/21 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), a BIMS summary score of "99", indicating that the resident had severely impaired cognition.

In Section G (Functional Status), ADL assistance: for transfers, toilet use, and personal hygiene, the resident was totally dependent and required two

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or more person's physical assistance from two or more staff.
For bed mobility, the resident required limited physical assistance from one staff member.
For dressing the resident required extensive physical assistance from one staff member

In Section J (Health Conditions), "Yes" to: resident have a fall any time in the last month prior to admission ...had a fracture related to a fall in the last 6 months prior to admission ... and had major surgery during the 100 days prior to admission ...

In Section O (Special Treatments, Procedures, and Programs), start date for Occupational and Physical Therapy "07/09/2021."

Review of Resident #409's medical record revealed the following:

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT (weight bearing as tolerated). Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach ..."

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain ..."

07/10/21 at 5:40 PM [SBAR] "...Resident transfer

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to [Hospital's Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She requested her mom to be transfer[ed] to the Hospital ..."

07/10/21 at 6:20 PM [Nurses Note-Late Entry] "...Family was at bedside visiting today from 11:45 AM Resident was seen by the medical director at 12:30 PM, ... At about 4 PM [the] daughter requested that she needed an X-ray to be done because she want[ed] to make sure her mothers' leg was not dislocated. Writer explains[ed] to the daughter that [the] resident has been seen by the doctor in her presen[ce] just a few hours ago. If there was any concern note[d] the doctor would have order[ed] an X-ray. She insisted that she want[ed] her mom to be sent to the hospital immediately because she need[ed] an X-ray to be done and read right [away]. Writer told her that an X-ray can be gotten from the doctor, but it will take b/n (between) 2-4 hours for the X-ray to be done ...[Physician's Name] was notified and the doctor said an X-ray will take about 4-6 hours to be done so the resident should be transfer[red] to the hospital via non-emergency transport for further evaluation per family request ...Resident was taken out from the facility at 5:50 [PM] to [Hospital's Name]."

07/12/21 at 6:34 PM [Hospital Discharge Summary] "The patient presents from [Name of Facility], where she has been staying for the past few days ... Her daughter and son-in-law went to

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F 607	Continued From page 70 visit her ... looked under her covers and found that her left leg was significantly inwardly rotated. They were concerned something is going wrong with the surgery at the left hip, and they requested transportation to the hospital ... Procedure -joint reduction: closed joint reduction (procedure for treating a hip dislocation without surgery, using manipulation of thigh bone (femur) to put the hip back in place) ED (Emergency Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced ...she tolerated the procedure well however did take 4 tries to get the hip in ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..." A review of Resident #409's medical record revealed no documented evidence that facility staff identified or investigated the resident's injury (dislocated hip) as an unusual occurrence. During a face-to-face interview on 04/20/22 at approximately 4:00 PM, Employee #8 (Unit Manager), stated, "The incident happened on a weekend, when I was not here. I am not sure why the facility did not investigate or file a report. The incident was documented in the progress notes and in an SBAR."	F 607		8/24/22
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		

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F 609	Continued From page 71 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 105 sampled residents, facility staff failed to: (1) report the unusual occurrences for Resident #3 and Resident #409 and (2) report the results of the investigation for Resident #408's injury of unknown origin. The findings include: Review of the facility's policy titled, "Prohibition of Abuse" with a revision date of 02/22, showed neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental	F 609	F609 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #3 was discharged home on 3/29/22, this deficient practice cannot be retroactively corrected Resident #409 was discharged home 9/28/2021, this deficiency cannot be retroactively corrected. Resident #408 was sent to ER on 2/12/22, this deficiency cannot be retroactively corrected.	8/24/22

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F 609	Continued From page 72 anguish, or emotional distress. The policy revealed that staff are to, "complete an incident/accident form for any unusual occurrences and submit it to the Director of Nursing or designee...A final report of the investigation will be reported and signed by the Administrator." 1. Facility staff failed to report Resident #3's heat and moisture exchanger (HME) being stuck in his stoma (unusual occurrence) and Resident #409's dislocated hip (unusual occurrence) to the state agency. A. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of an intake form for a complaint received by the DC Department of Health, Health Care Regulation and Licensing Administration on 01/26/22 showed the complainant [granddaughter] alleged that Resident #3 was rushed to the ER on 12/03/21, "which could have been fatal ...because there was an HME put into his (Resident #3) neck stoma (airway)." Review of an Admission Minimum Data Set (MDS) dated 12/03/21 showed that facility staff left "Brief Interview Mental Summary Score" section blank. In Section I (Active Diagnoses), Cancer, Malignant Neoplasm of Laynx, Surgical Aftercare Following Surgery of Respiratory system, Weakness, Tracheostomy Status and Malignant Neoplasm of Supraglottis.	F 609	F609 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: The facility currently has one resident with an HME stoma.(tracheostomy) Unit Manager / Designee will conduct weekly audit on their units to ensure that injuries of unknown origin are investigated and reported. Also, to ensure resident with respiratory diagnosis are in no form of respiratory distress , that the facility have adequate respiratory supply to meet the resident respiratory needs. Any issues found will be addressed by 8/24/22	8/24/22

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F 609	Continued From page 73 In Section O (Special Treatment, Procedures, and Programs), the resident was coded for receiving tracheostomy care and speech therapy services. The resident was not coded for respiratory therapy services. Review of the resident's medical record revealed the following: Physician's Orders: 12/02/21 "Change HME daily day shift" 12/03/21 "Transfer resident to the nearest ER for further evaluation related to stuck HME in stoma" 12/04/21 "Do not occlude stoma in neck. The oatient [patient] is an obligate neck breather" Progress Notes: 12/01/21 at 8:29 PM [Physician Assistant Progress Note] "Pt. (patient) seen at bedside appears alert and stable ...Pt. also has tracheostomy and doing well ...vitals: 126/81 (blood pressure), 86 (pulse, 18 (respiration), 97.6 (temperature), 95% RA (oxygen saturation rate on room air) ... " 12/02/21 at 1:15 PM [Respiratory Therapy Assessment] "Type- initial assessment, Resident was alert and oriented with lary tube and holder in place with an HME. Lary tube cleaned, tube holder changed. HME changed. Pre-treatment assessment respiratory rate 18, SPO2 98% [on] room air, lung sounds clear ... Post-treatment assessment respiratory rate 18, SPO2 (peripheral capillary oxygen saturation) 99% on room air,	F 609	F609 MEASURES TO PREVENT RECURRENCE: Supervisors will conduct daily rounds during their shift to ensure that residents with stoma site that aids with respiration present with clean stoma sites. Any issues found will be corrected by 8/24/2022. In- service will be provided by Staff Educator /Designee to all Licensed nursing staff (LPN/ RN) on how to assess resident with a stoma and to report their findings by 8/24/2022. Charge nurses /Designee will investigate and report injuries of unknown origins during their shift. Any issues found will be corrected by 8/24/22 Respiratory therapist will ensure that residents with respiratory issues are in no form of respiratory distress during their shift. Findings will be addresses by 8/24/22 Unit managers/ designee will conduct weekly audits to ensure that residents with respiratory distress are assessed for respiratory distress and documentation is in place. Findings will be corrected by 8/24/22 DON / Designee will ensure incidents/ accidents that occurred within the week are reported. Findings will be addressed by 8/24/22	8/21/22

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F 609	Continued From page 74 lung sounds clear ..." 12/03/21 at 2:42 PM [Nursing Progress Note] "The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME [was] initially stuck down in stoma (airway) and the resident coughed it up ...911 called at 1345 (1:45 PM) and they arrived at 1400 (2:00 PM). However, review of respiratory therapy assessments / infection screener notes] lacked documented evidence that the respiratory therapist assessed or provided care for Resident #3 from 12/02/21 to 12/06/21." 12/04/21 [Hospital Discharge Summary] "Diagnosis-tracheostomy malfunction. Diagnostic radiology XR (xray) neck soft tissue, XR chest PA (posterior-anterior) and LAT (lateral) 2 view. Call for follow-up appointment with physician within 2 to 4 days [provided education tool] for "How to Clean a Tracheostomy Tube, Adult." 12/06/21 at 4:13 PM [Physician Assistant Progress Note] "Re-admission follow-up, pt (patient) was hospitalized for tracheostomy	F 609	F 609 MONITORING CORRECTIVE ACTIONS: DON/Designee will conduct audits to ensure that resident with a stuck stoma incident is reported, and that injuries with incident of unknown origin are also investigated and reported. This audit will be conducted weekly x4, then monthly x3, findings will be corrected immediately and reported to QAPI committee.	8/24/22

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malfunction. Pt. seen at the bedside appears alert and stable ...vitals: 130/67 (blood pressure), 71 (pulse), 17 (respirations) , 97% RA (oxygen saturation rate on room air) ...resp (respiration): lung CTA (Clear to auscultate), BL (bilaterally)."

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that she informed the staff that Resident #3's HME was "stuck in his stoma (airway). I'm not sure how the HME got stuck in his stoma."

During a face-to-face interview on 04/18/22 at 11:24 AM, Employee #2 (Director of Nursing) was asked when, per the Abuse Policy, during the unusual occurrence when Resident #3's HME was stuck in his stoma should staff have investigated to ensure the resident was not neglected by staff? The employee stated, "I don't know the situation to give you an accurate answer."

B. Review of an intake form for a complaint received by the State agency on 12/06/21 documented " ...after having hip surgery on 07/08/21, was observed two days later on 07/10/21 with "leg positioned like the letter 'K'...." Resident #409 was sent to the hospital for a dislocated hip and hip surgery.

Resident #409 was admitted to the facility on 07/08/21 with diagnoses that included: Encounter for Orthopedic Aftercare, Presence of Left Artificial Hip Joint, Alzheimer's Disease (Unspecified), Repeated Falls, Muscle Weakness (Generalized), and Other Abnormalities of Gait and Mobility.

A review of the Quarterly MDS for Resident #409

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dated 07/11/21 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), a BIMS summary score of "99", indicating that the resident had severely impaired cognition.

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT (weight bearing as tolerated). Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach..."

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain..."

07/10/21 at 5:40 PM [Situational, Background Assessment Request (SBAR) Communication Tool] " ...Resident transfer to [Hospital Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She requested her mom to be transfer[ed] to the Hospital ..."

07/10/21 at 6:20 PM [Nurses Note-Late Entry]

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"...Family was at bedside visiting today from 11:45 AM Resident was seen by the medical director at 12:30 PM... At about 4 PM [the] daughter requested that she needed an X-ray to be done because she want[ed] to make sure her mothers' leg was not dislocated. Writer explains[ed] to the daughter that [the] resident has been seen by the doctor in her presen[ce] just a few hours ago. If there was any concern note[d] the doctor would have order[ed] an X-ray. She insisted that she want[ed] her mom to be sent to the hospital immediately because she need[ed] an X-ray to be done and read right [away]. Writer told her that an X-ray can be gotten from the doctor, but it will take b/n (between) 2-4 hours for the X-ray to be done ...[Physician's Name] was notified and the doctor said an X-ray will take about 4-6 hours to be done so the resident should be transfer[red] to the hospital via non-emergency transport for further evaluation per family request ...Resident was taken out from the facility at 5:50 [PM] to [Hospital's Name]."

07/12/21 at 6:34 PM [Hospital Discharge Summary] "The patient presents from [Name of Facility], where she has been staying for the past few days ... Her daughter and son-in-law went to visit her ... looked under her covers and found that her left leg was significantly inwardly rotated. They were concerned something is going wrong with the surgery at the left hip, and they requested transportation to the hospital ... Procedure -joint reduction: closed joint reduction (procedure for treating a hip dislocation without surgery, using manipulation of thigh bone (femur) to put the hip back in place) ED (Emergency Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced ...she tolerated the procedure well however did take 4 tries to get the

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hip in ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..."

A review of Resident #409's medical record revealed no documented evidence that facility staff reported this unusual occurence to the Department of Health.

During a face-to-face interview with Employee #8 (Unit Manager/Registered Nurse) on 04/20/22 at approximately 4:00 PM, he stated, "The incident happened on a weekend, when I was not here. I am not sure why the facility did not investigate or file a report. The incident was documented in the progress notes and in an SBAR."

2. Facility staff failed to report the results of the investigation for Resident #408's injury of unknown origin.

Review of the FRI dated 02/22/22 documented, "...Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP (Nurse Practitioner) ... X-ray report received this morning with impression of Acute fracture of the left distal femur, Acute hairline fracture of the right lateral femoral condyle ... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident had reported fallen to anyone ..."

Resident #408 was admitted to the facility on 05/25/21 with multiple diagnoses that included: Hemiplegia and Hemiparesis, Hypocalcemia, Muscle Weakness and Lack of Coordination.

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Review of Resident #408's medical record revealed the following:

01/04/22 [Quarterly MDS], facility staff coded the following: a BIMS summary score "04", indicating severe cognitive impairment, extensive assistance to total dependence with two plus persons physical assist for transfers, mobility and personal hygiene and no impairment in range of motion.

02/16/22 at 2:27 PM [Nurse Practitioner (NP) Progress Note] "Assessment and f/u (follow up) knee pain ... seen today for assessment due to c/o (complain of) pain on both knees. She admits to moderate pain in her knees, dull and affecting her sleep ... Plan [x-ray] on both knees ..."

02/17/22 at 7:38 AM [Nurses Note] "Resident's X-ray of the both knees (Positive) for LT (left) knee: There is a fracture of the distal femur with displacement ... RT (right) Knee: There is irregularity and impaction and a cortical hairline fracture of the distal lateral femoral metaphysis which is impacted... A call placed to the NP ..."

02/17/22 at 12:05 PM [Nurses Note] " ... Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP ... NP ordered X-rays of bilateral knees. X-ray report received this morning with impression of acute fracture of the left distal femur, acute hairline fracture of the right lateral femoral condyle in normal alignment... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident had reported fallen to anyone. [Physician's Name] notified and she gave order to send resident to the ER for 2nd opinion ..."

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F 609	Continued From page 80 Review of the facility's investigation documents provided to the surveyor on 04/18/22 at 10:36 AM revealed the facility staff failed to report the results of Resident #408's investigation of an injury of unknown origin to the state agency. During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #7 (Clinical Coordinator) acknowledged the finding and stated, "The investigation was not concluded. The resident was sent immediately to the hospital. She did not come back to the facility for us to conclude the investigation."	F 609		8/24/22
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for	F 610		

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F 610	Continued From page 81 six (6) of 105 sampled residents, facility staff failed to: (1) conduct investigations for unusual occurrences for Residents' #3 and #409; (2) conduct investigations of resident-to-resident altercations with Residents' #67, #71 and #151; and (3) conduct a thorough investigation of Resident #221's threat of violence against his roommate. The findings include: Review of the facility's policy titled, "Prohibition of Abuse" with a revision date of 02/2022, showed neglect was defined as the failure of the facility, 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 policy revealed that staff are to "complete an incident/accident form for any unusual occurrences and submit it to the Director of Nursing or designee ...A final report of the investigation will be reported and signed by the Administrator...If suspected abuse/inappropriate behavior are between two residents, residents will be immediately separated from each other and monitored until appropriate interventions are implemented... All employees will sign a memo attesting, their understanding and compliance to abuse standards..." 1.Facility staff failed to conduct investigations for Resident #3's heat and moisture exchanger (HME) being stuck in his stoma (unusual occurrence) and Resident #409's dislocated hip (unusual occurrence). A. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including	F 610	F610 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 3 was discharged 3/29/22,this deficient practice cannot be retroactively corrected. Resident # 409 was discharged home on 9/28/20 this deficient practice cannot be retroactively corrected. Resident #71 was assessed from head to toe on 4/26/22,for bruises redness and pain. resident suffered no negative outcome from the incident that occurred between him and another resident and denied pain. MD/RP updated 4/26/22 Resident #67 was assessed by Unit Manager from head to toe on 4/26/22, for bruises, redness and pain ,resident suffered no negative outcome. Resident denied pain .MD/RP update 4/26/22 Resident #151 was assessed from head to toe by Unit Manager on 4/26/22 for redness bruises and pain. Resident suffered no negative outcome from the incident that happened between him and another resident and denied pain. MD/RP updated on 4/26/22 Resident #221 signed out AMA on 5/19/22 this deficient practice cannot be retroactively corrected. Resident # 408 was sent to ER on 2/12/22 and did not return to the facility.	8/24/22

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F 610	Continued From page 82 Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of an intake form for a complaint received by the DC Department of Health, Health Care Regulation and Licensing Administration on 01/26/22 showed the complainant [granddaughter] alleged that Resident #3 was rushed to the ER on 12/03/21, "which could have been fatal ...because there was an HME put into his (Resident #3) neck stoma (airway)." Review of an Admission Minimum Data Set (MDS) dated 12/03/21 showed that facility staff left "Brief Interview Mental Summary Score" section blank. In Section I (Active Diagnoses), Cancer, Malignant Neoplasm of Laynx, Surgical Aftercare Following Surgery of Respiratory system, Weakness, Tracheostomy Status and Malignant Neoplasm of Supraglottis. In Section O (Special Treatment, Procedures, and Programs), the resident was coded for receiving tracheostomy care and speech therapy services. The resident was not coded for respiratory therapy services. Review of the resident's medical record revealed the following: Physician's Orders: 12/02/21 "Change HME daily day shift" 12/03/21 "Transfer resident to the nearest ER for further evaluation related to stuck HME in stoma"	F 610	F610 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents residing in the facility have the potential to be affected by this deficient practice. Clinical care coordinator/Designee will conduct house wide audit to ensure that all resident-to-resident altercation are fully investigated, and that all staff present provided statements. Any issues found will be corrected by 8/24/22. Unit Managers/ Supervisors will conduct house wide audit to ensure that all alleged threat of violence is investigated and reported. Any issues found will be corrected by 8/24/22.	8/24/22

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F 610	Continued From page 83 12/04/21 "Do not occlude stoma in neck. The oatient [patient] is an obligate neck breather" Progress Notes: 12/01/21 at 8:29 PM [Physician Assistant Progress Note] "Pt. (patient) seen at bedside appears alert and stable ...Pt. also has tracheostomy and doing well ...vitals: 126/81 (blood pressure), 86 (pulse, 18 (respiration), 97.6 (temperature), 95% RA (oxygen saturation rate on room air) ... " 12/02/21 at 1:15 PM [Respiratory Therapy Assessment] "Type- initial assessment, Resident was alert and oriented with lary tube and holder in place with an HME. Lary tube cleaned, tube holder changed. HME changed. Pre-treatment assessment respiratory rate 18, SPO2 98% [on] room air, lung sounds clear ... Post-treatment assessment respiratory rate 18, SPO2 (peripheral capillary oxygen saturation) 99% on room air, lung sounds clear ..." 12/03/21 at 2:42 PM [Nursing Progress Note] "The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma	F 610	F610 MEASURES TO PREVENT RECURRENCE: In-service will be provided to all licensed nurses by Staff Educator on the importance of completing accident/incident report accurately and to report their findings to DOH within forty-eight hours except incidents or accidents that resulted in harm which is to be reported within eight hours of occurrence by 8/24/2022. Repeat in-service will be conducted as needed. Unit Managers will ensure that all staff members provide written statements on resident incidents/ accidents situations .Any findings will be corrected by 8/24/22. Supervisors will ensure all incident/accident reports are completed accurately. Any issues found will be corrected by 8/24/22 Charge nurses will ensure that they collect statements from staff about incident/accident that occurred during their shifts and ensure that incidents are reported. Any issues found will be corrected by 8/24/22	8/24/22

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F 610	Continued From page 84 was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME [was] initially stuck down in stoma (airway) and the resident coughed it up ...911 called at 1345 (1:45 PM) and they arrived at 1400 (2:00 PM). However, review of respiratory therapy assessments / infection screener notes] lacked documented evidence that the respiratory therapist assessed or provided care for Resident #3 from 12/02/21 to 12/06/21." 12/04/21 [Hospital Discharge Summary] "Diagnosis-tracheostomy malfunction. Diagnostic radiology XR (xray) neck soft tissue, XR chest PA (posterior-anterior) and LAT (lateral) 2 view. Call for follow-up appointment with physician within 2 to 4 days [provided education tool] for "How to Clean a Tracheostomy Tube, Adult." 12/06/21 at 4:13 PM [Physician Assistant Progress Note] "Re-admission follow-up, pt (patient) was hospitalized for tracheostomy malfunction. Pt. seen at the bedside appears alert and stable ...vitals: 130/67 (blood pressure), 71 (pulse), 17 (respirations), 97% RA (oxygen saturation rate on room air) ...resp (respiration): lung CTA (Clear to auscultate), BL (bilaterally)." During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that she informed the staff that Resident #3's HME was "stuck in his stoma (airway). I'm not sure how the HME got stuck in his stoma." During a face-to-face interview on 04/18/22 at 11:24 AM, Employee #2 (Director of Nursing) was asked when, per the Abuse Policy, during the unusual occurrence when Resident #3's HME	F 610	Unit Managers will validate during grand rounds daily that incidents that occurred in the facility have been reported to DOH and that the responsible party has been notified. Any issues found will be addressed by 8/24/22. Audit will be conducted by Nurse Supervisors, ADON/ Designee, to ensure that incidents are investigated, that the incident forms are completed accurately and that incidents are reported in a timely manner to Department of Health. Any issues found will be corrected by 8/24/22.	8/24/22

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F 610	Continued From page 85 was stuck in his stoma should staff have investigated to ensure the resident was not neglected by staff? The employee stated, "I don't know the situation to give you an accurate answer." B. Resident #409 was admitted to the facility on 07/08/21 with diagnoses that included: Encounter for Orthopedic Aftercare, Presence of Left Artificial Hip Joint, Alzheimer's Disease (Unspecified), Repeated Falls, Muscle Weakness (Generalized), and Other Abnormalities of Gait and Mobility. Review of an intake form for a complaint received by the State agency on 12/06/21 documented " ...after having hip surgery on 07/08/21, was observed two days later on 07/10/21 with "leg positioned like the letter 'K'...." Resident #409 was sent to the hospital for a dislocated hip and hip surgery. A review of the Quarterly MDS for Resident #409 dated 07/11/21 revealed that facility staff coded the following: In Section C (Cognitive Patterns), a BIMS summary score of "99", indicating that the resident had severely impaired cognition. 07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT (weight bearing as tolerated). Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach ..."	F 610	F610 MONITORING CORRECTIVE ACTION: DON/Designee will audit all incident report to ensure that they are fully investigated upon and that each incident report has employees' statements. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately and reported to the QAPI committee	8/24/22

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F 610	Continued From page 86 07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain ..." 07/10/21 at 5:40 PM [Situational, Background Assessment Request (SBAR) Communication Tool] " ...Resident transfer to [Hospital Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She requested her mom to be transfer[ed] to the Hospital ..." 07/10/21 at 6:20 PM [Nurses Note-Late Entry] "...Family was at bedside visiting today from 11:45 AM Resident was seen by the medical director at 12:30 PM... At about 4 PM [the] daughter requested that she needed an X-ray to be done because she want[ed] to make sure her mothers' leg was not dislocated. Writer explains[ed] to the daughter that [the] resident has been seen by the doctor in her presen[ce] just a few hours ago. If there was any concern note[d] the doctor would have order[ed] an X-ray. She insisted that she want[ed] her mom to be sent to the hospital immediately because she need[ed] an X-ray to be done and read right [away]. Writer told her that an X-ray can be gotten from the doctor, but it will take b/n (between) 2-4 hours for the X-ray to be done ...[Physician's Name] was notified and the	F 610		8/24/22

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F 610	Continued From page 87	F 610		8/24/22

doctor said an X-ray will take about 4-6 hours to be done so the resident should be transfer[red] to the hospital via non-emergency transport for further evaluation per family request ...Resident was taken out from the facility at 5:50 [PM] to [Hospital's Name]."

07/12/21 at 6:34 PM [Hospital Discharge Summary] "The patient presents from [Name of Facility], where she has been staying for the past few days ... Her daughter and son-in-law went to visit her ... looked under her covers and found that her left leg was significantly inwardly rotated. They were concerned something is going wrong with the surgery at the left hip, and they requested transportation to the hospital ... Procedure -joint reduction: closed joint reduction (procedure for treating a hip dislocation without surgery, using manipulation of thigh bone (femur) to put the hip back in place) ED (Emergency Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced ...she tolerated the procedure well however did take 4 tries to get the hip in ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..."

A review of Resident #409's medical record revealed no documented evidence that facility staff identified or investigated the resident's injury (dislocated hip) as an unusual occurrence and failed to conduct an investigation.

During a face-to-face interview on 04/20/22 at approximately 4:00 PM, Employee #8 (Unit Manager) stated, "The incident happened on a weekend, when I was not here. I am not sure why the facility did not investigate or file a report. The

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F 610	Continued From page 88	F 610		8/24/22

incident was documented in the progress notes and in an SBAR."

2. Facility staff failed to investigate two incidences of resident-to-resident altercations involving Residents' #71, #67 and #151.

Review of the Facility Reported Incident (FRI) dated 12/09/21 documented, "... At 0730 AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Review of the FRI dated 01/02/22 documented, "...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby..."

Resident Background Information

A. Resident #151 was admitted to the facility on 10/22/20 with multiple diagnoses that included: Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia.

Review of Resident #151's medical record revealed:

12/08/21 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe cognitive impairment.

In Section E (Behavior):

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical

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behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - "Behavior of this type occurred 1 to 3 days", verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - "Behavior of this type occurred 4 to 6 days", Impact on Resident ... Put the resident at significant risk for physical illness or injury? "yes"; impact on others ... put others at significant risk of physical injury? "yes"; significantly intrude on the privacy or activity of others? "yes"; significantly disrupt care or living environment? "yes"

In Section G (Functional Status): Activities of Daily Living (ADL) Assistance - bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, Resident #151 required "supervision" and "one person physical assist"

Review of the Care Plan revealed:

07/27/21 (Revision date) "As evidenced by a positive PASARR (Preadmission Screening and Resident Review) Level I screen and Level II evaluation, it was determined that the resident needs Specialized Services while in the Nursing Facility. Related to: schizophrenia ...Inform the MD (medical doctor) if the Individual has a serious health decline and services previously agreed to may need to be modified or deleted. Inform the MD of any significant changes may require additional evaluation to add, modify or remove services ..."

07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..."

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F 610	Continued From page 90 10/18/21 (Revision date) "[Resident #151] has problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with taking medications, non compliant with vital signs, non compliant with shaving and showers. Non compliant with Wader guard placement kicking and hitting ..." 10/20/21 (Revision date) "[Resident #151] has impaired cognitive function or impaired thought processes r/t (related to) Dementia..." 10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..." 10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..." B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension.	F 610		8/24/22

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Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21where facility staff coded a BIMS summary score of "09", indicating moderate cognitive impairment, no potential indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions.

C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance.

Review of Resident #67's medical revealed, a Quarterly MDS dated 11/06/21 where facility staff coded a BIMS summary score of "14", indicating intact cognitive response, no potential indicators of psychosis, no physical or verbal behavioral symptoms, limited to extensive assistance with one person physical assist for ADLs and no limitations in range of motion.

Altercation #1 involving Residents #151 and #71:

12/08/21 at 11:18 AM [Nurses Note] " ... At 0730AM, the [Security Officer's Name] and the [Receptionist's Name] observed resident [#151] assaulting another resident [Resident #71] at the front of the building. The security officer and the receptionist ran to the residents and separated both residents... [Resident #71] was interviewed. He said, 'the man jumped on me in front of the building for no reason. I have never spoken to him. I don't know where this came from today' ... asked [Resident #151] why he assaulted [Resident #71]. He said, 'he raped my daughter' ... The MPD (Metropolitan Police Department)

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was called ... took [Resident #151] because of his aggressive behavior and transported him to [Hospital Name] at 0809 (AM) for evaluation. [Resident #71] was assessed and small scratch mark observed on the back of his left hand..."

Altercation #2 involving Residents #151 and #67:

12/30/21 at 11:30 AM [Nurses Note] "... At 2030 (8:30 PM) on 12/29/2 (12/29/21).., Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby; the receptionist notified the supervisor; the supervisor assessed [Resident #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45 PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site. No swelling, discoloration or open area observed during assessment. He denied pain ..."

During a face-to-face interview conducted on 04/14/22 at 2:45 PM, Employee #6 (Administrator in Training) was asked to provide the facility's investigation documents related to the two incidences of resident-to-resident altercations involving Residents #71, #67 and #151. The Employee stated, "It was reported to DOH (Department of Health) but no investigations were done."

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The evidence showed that facility staff failed to implement its written policies and procedures for investigations evidenced by failure to conduct an investigation of two resident-to-resident altercations.

2. Facility staff failed to thoroughly investigate an alleged threat of violence by Resident #221.

Review of the FRI (Facility Reported Incident) dated 03/29/22, documented "...resident explained to the charge nurse that he did not like rooming with his roommate. He stated that if he were to continue to be in that room that one day we will find the roommate hurt..."

Resident #221 was re-admitted to the facility on 10/28/21 with multiple diagnoses including, Cognitive Communication Deficit, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Paraplegia Unspecified and Paranoid Schizophrenia.

Review of the Quarterly MDS dated 03/23/22 revealed that the facility staff coded the following: In section C (Cognitive Patterns), a BIMS) Summary Score "15", indicating intact cognition.

Review of the document titled "SBAR (Situation Background Assessment Request)-physician /NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool" dated 03/28/22 at 12:27 PM, showed "...Today, resident explained to the charge nurse that he did not like rooming with his roommate. He stated that if he were to continue to be in that room that one day, we will find the roommate in a pool of blood. A nurse stayed by the resident's side until the resident could be

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transferred to another room. Prior to being transferred to the room he was introduced to the new potential roommate and stated that the change would be fine. ..."

Review of the facility's incident investigation documentation that was signed and dated on 03/28/22, consisted of the following: two handwritten employee statements, a copy of a resident face sheet, a form titled "Incident/Accident report", a form titled "Quality Assurance and Performance Improvement Employee /Resident investigation report, a SBAR note, a form titled Pain evaluation for cognitively impaired & Intact.

Review of the facility's incident investigation documentation that was signed and dated on 03/28/22, consisted of the following: two handwritten employee statements, a copy of a resident face sheet, a form titled "Incident/Accident report", a form titled "Quality Assurance and Performance Improvement Employee /Resident investigation report, a SBAR note, a form titled Pain evaluation for cognitively impaired & Intact.

The facilities investigative report lacked documented evidence of the following: an interview or assessment of Resident #221's roommate, interviews with all staff that had knowledge of the incident and resident and staff education/training related to care approaches following the resident-to-resident incident.

During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #2 (Director of Nursing) acknowledged the findings.

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4. Facility staff failed to thoroughly investigate Resident #408's injury of unknown origin interview evidenced by failure to interview and/or obtain statements from all staff involved in Resident #408's care.

Review of the FRI dated 02/22/22 documented, "...Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP (Nurse Practitioner) ... X-ray report received this morning with impression of Acute fracture of the left distal femur, Acute hairline fracture of the right lateral femoral condyle ... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident had reported fallen to anyone..."

Resident #408 was admitted to the facility on 05/25/21 with multiple diagnoses that included: Hemiplegia and Hemiparesis, Hypocalcemia, Muscle Weakness and Lack of Coordination.

Review of Resident #408's medical record revealed the following:

01/04/22 [Quarterly MDS], facility staff coded the following: a BIMS summary score "04", indicating severe cognitive impairment, extensive assistance to total dependence with two plus persons physical assist" for transfers , mobility and personal hygiene, no impairment in range of motion.

02/16/22 at 2:27 PM [Nurse Practitioner (NP) Progress Note] "Assessment and f/u knee pain ... seen today for assessment due to c/o pain on both knees. She admits to moderate pain in her knees, dull and affecting her sleep ... Plan [x-ray]

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F 610	Continued From page 96 on both knees ..." 02/17/22 at 7:38 AM [Nurses Note] "Resident's X-ray of the both knees (Positive) for LT (left) knee: There is a fracture of the distal femur with displacement ... RT (right) Knee: There is irregularity and impaction and a cortical hairline fracture of the distal lateral femoral metaphysis which is impacted... A call placed to the NP ..." 02/17/22 12:05 PM [Nurses Note] " ... Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP ... NP ordered X-rays of bilateral knees. X-ray report received this morning with impression of acute fracture of the left distal femur, acute hairline fracture of the right lateral femoral condyle in normal alignment... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident had reported fallen to anyone. [Physician's Name] notified and she gave order to send resident to the ER for 2nd opinion ..." Review of the facility's investigation documents provided to the surveyor on 04/18/22 at 10:36 AM revealed the facility staff failed to report the results of Resident #408's investigation of an injury of unknown origin. During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM with Employee #7(Clinical Coordinator), he acknowledged the finding and stated, "The investigation was not concluded. The resident was sent immediately to the hospital. She did not come back to the facility for us to conclude the investigation."	F 610		8/24/22

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F 610	Continued From page 97 Review of the facility's investigation documents provided to the surveyor on 04/18/22 at 10:36 AM revealed the facility staff failed to interview and/or obtain a statement from the licensed staff assigned to Resident #408 on 02/16/22 during the day shift (7:00 AM - 3:00 PM). During a face-to-face interview conducted on 04/18/2022 at approximately 1:30 PM with Employee #43 (2nd Floor Unit Manager), she acknowledged the finding and made no further comments.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including	F 622	F622 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #3 was discharged home on 3/29/22. Resident # 126 was assessed from head to toe on 4/26/22, by Unit Manager, resident suffered no negative outcome.MD/RP notified on 4/26/22 Resident #155 was assessed from head to toe on 4/26/22 by unit manager, resident suffered no negative outcome. MD/RP notified on 4/26/22	

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F 622	Continued From page 98 Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-	F 622	4F622 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. House wide audit will be conducted by Unit Managers, DON/ ADON/ Supervisors to ensure that care plan goals. are sent to the receiving hospital when the resident is transferred. Any issues found will be addressed by 8/24/22	8/24/22

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F 622	Continued From page 99 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 105 sampled residents, the facility's staff failed to ensure: (1) Resident #3's discharge, transfer, or relocation form dated 12/03/21 included accurate information and (2) Resident #126's and #155's care plan goals were sent to the receiving hospital. The findings include: 1. The facility's staff failed to ensure Resident #3's discharge, transfer, or relocation form dated 12/03/21 included the accurate information. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including	F 622	F622 MEASURES TO PREVENT RECURRENCE: In service will be provided to all licensed clinical team members by Staff Educator/ Designee on the importance of sending care plan goals with the resident when sending a resident to the hospital . Repeat in-services provided as needed. Supervisors will ensure that care plan goals are included in the transfer package when sending a resident to the hospital. Any issues will be corrected by 8/2422. Unit Managers will ensure that charge nurses print a copy of a patient's care plan goal and send it with the resident when he/she is leaving for the hospital. Any issues found will be corrected by 8/24/22. Clinical care coordinators will ensure that every resident that is transferred to the hospital has care plan goals printed and attached to all transfer to hospital documents. Any issues found will be corrected by 8/24/22.	8/24/22

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F 622	Continued From page 100 Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of the Resident #3's medical record showed a physician's order dated 12/03/21 that instructed, "transfer resident to the nearest ER (emergency room) for further evaluation related to stuck HME in stoma." 12/03/21 at 2:42 PM [Nursing Progress Note] "The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME initially stuck down in stoma (airway) and the resident coughed it up ...911 called at 1345 and they arrived at 1400. However, review of respiratory therapy assessments / infection screener notes] lacked documented evidence that the respiratory therapist assessed or provided care for Resident #3 from 12/02/21 to 12/06/21." Review of a Department of Health Notice of Discharge, Transfer or Relocation Form dated 12/03/21 from the facility documented, "	F 622	F622 MONITORING CORRECTIVE ACTIONS: DON/Designee will validate that clinical coordinator, Unit managers and supervisors ensured that care plan goals were printed and sent with the resident when the resident was sent to the hospital. Findings will be corrected immediately. This audit will be conducted weekly x4, then monthly x3, report will be presented to QAPI committee	8/24/22

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...Transfer - Hospital ... [resident's name] went to an appointment [and] [was] admitted."

During a face-to-face interview on 04/18/22 at 11:32 AM, Employee #11 (Director of Social Services) stated that it was an error, and she got the information that Resident #3 was transferred to the hospital from an appointment from the facility's census.

2. The facility's staff failed to ensure Residents #126's and #155's care plan goals were sent to the receiving hospital(s) when the residents were transferred out.

A. Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Heart Failure Unspecified, Presence of Right Artificial Knee Joint, Chronic Kidney Disease, Stage 4 (Severe), and Other Lack of Coordination.

Review of Resident #126's medical record revealed:

A Quarterly Minimum Data Set (MDS) dated 02/17/22, revealed that the facility staff coded a Brief Interview for Mental Status (BIMS) summary score "09", indicating moderately impaired cognition.

03/29/22 at 3:59 PM [Nurses Progress Note] "Resident was observed with swelling around the right knee surgical area and the NP (Nurse Practitioner) ...was made aware and she order to send resident out to [Hospital Name] for Orthopedic to evaluate right knee surgical area with possible Abcess (sp) infection ..."

There was no documented evidence to show that

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facility staff included Resident #126's care plan goals in the transfer packet provided to the receiving hospital.

B. Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses that included: Essential (Primary) Hypertension, Dysphagia, Oropharyngeal Phase, Unspecified Lack of Coordination, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Dominant Side.

A Quarterly MDS dated 02/18/22, showed that facility staff coded Resident #155 with a BIMS summary score of "05", indicating severe cognitive impairment.

Review of the document titled, "Situation Background Assessment Request (SBAR) ... Communication Tool" showed, 03/30/22 at 6:40 PM, "Resident is alert and verbally responsive Resident complaint of chest pain radiating to the abdomen. NP ... ordered to be transferred to the hospital for further evaluation. Writer called 911 at 3:15 PM, arrived at 3:23 PM and left with resident at 4:04 PM to [Hospital name]. Resident left with the following documents: Doctors ordered (sp) to be transferred, physician progress notes, medication list, full code, face sheet, labs result, immunization record, bed hold policy..."

Facility staff was unable to provide the writer with evidence that Resident #155's care plan goals were part of the transfer packet provided to the receiving hospital.

During a face-to-face interview conducted on 04/18/22 at 11:43 AM, Employee #2 (Director of Nursing) acknowledged that the facility did not

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F 622	Continued From page 103 send Resident #126's or Resident #155's care plan goals to the receiving provider.	F 622		8/24/22
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623	F 623 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 3 was discharged home 3/29/2022 Resident #406 was sent to the hospital 2/10/2022. He did not return to the facility. This deficiency cannot be retroactively corrected. Resident #132 incident cannot be retroactively corrected. Resident #82 was assessed by Unit Manager on 4/26/2022, resident suffered no negative outcome.MD/RP notified on 4/26/2022.Resident taken by DC police into custody on 7/20/22 Resident #404 was sent to the hospital on , 2/21/22 and expired. Deficient practice cannot be retroactively corrected.	

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F 623	Continued From page 104 under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder	F 623	F 623 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. House wide audit will be conducted by Unit Managers and Clinical care coordinator to ensure that the reason for transfer to hospital is indicated on all residents who have been sent to the hospital and that the responsible parties are updated of a resident s room relocation and documented in the residents' clinical record. Any issues will be corrected 8/24/22. Unit manager will ensure that a written notification is sent to the resident's #233 responsible party about room relocation by 8/24/22	8/24/22

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F 623	Continued From page 105 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for six (6) of 105 sampled residents, the facility staff failed to: (1) notify Resident #3's, #132's and #406's representative(s) in writing the reason for the resident's transfer to a hospital and (2) provide written notification to Resident #82's, #233's and #404's representatives of room relocation. The findings include: 1.Facility staff failed to: (1) notify Resident #3's, #132's and #406's representative(s) in writing the reason for the resident's transfer to a hospital. 1A. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including	F 623	F623 MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Educators / Designee to all licensed nursing staff to ensure that the reason for transferring a resident to the hospital is indicated and provided in the package that is sent with the resident to the hospital by 8/24/2022. Repeat in-service provided as needed. Supervisors will ensure weekly that the nurses are indicating the reason for transfer of a resident to the hospital and notify the responsible party. Any issues found will be corrected by 8/24/22, Unit Managers will ensure on a weekly basis that the charge nurses are including the reason for transfer to hospital and that the responsible party is updated. Any issues found will be corrected by 8/24/22. ADON/Designee will ensure weekly, that the licensed nurses indicate the reason for transfer once it is determined that the resident must go to the hospital and update the responsible party. Any issues found will be corrected by 8/24/22.	~~8/24/22~~

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F 623	Continued From page 106 Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of the Resident #3's medical record showed a physician's order dated 12/03/21 that instructed, "Transfer resident to the nearest ER (emergency room) for further evaluation related to stuck humified moisture exchange (HME) in stoma." 12/03/21 at 2:42 PM [Nursing Progress Note] "The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME initially stuck down in stoma (airway) and the resident coughed it up ...911 called at 1345 and they arrived at 1400. However, review of respiratory therapy assessments / infection screener notes] lacked documented evidence that the respiratory therapist assessed or provided care for Resident #3 from 12/02/21 to 12/06/21." Review of a Department of Health Notice of Discharge, Transfer or Relocation Form dated	F 623	Unit Mangers/Designee will ensure that nurses notify responsible parties of a resident's room relocation. Any issues will be corrected by 8/24/22. F623 MONITORING CORRECTIVE ACTIONS: DON/ Designee will ensure that all residents have documented reason for transfer to the hospital. Will also ensure that responsible parties are notified of resident's relocation. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately, and report presented to QAPI committee.	8/24/22

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F 623	Continued From page 107	F 623		8/24/22

12/03/2021 from the facility lacked documented evidence the resident's representative was made aware in writing Resident #3's reason for transfer to the emergency room on 12/03/21.

During a face-to-face interview on 04/18/22 at 11:32 AM, Employee #11 (Director of Social Services) stated that she did not notify in writing Resident #3's representative of the reason for his transfer to the ER on 12/03/21.

1B. Resident #132 was readmitted to the facility on 02/11/22 with diagnoses that included: Urinary Tract Infection, Alzheimer's, Dementia, Epilepsy and Muscle Weakness (Generalized).

A review of the Quarterly MDS dated 02/17/22 revealed that facility staff coded Resident #132 with a BIMS Summary Score of "99," indicating that the resident had severely impaired cognition.

02/02/22 11:44 AM [Nurses Note]: "At 10.15 AM resident was noted with crackles, chest congestion, labored breathing and SOB (shortness of breath) with sat (saturation) at 88%... 911 called and arrived to the unit at 10.40 am. After assessment. EMS (emergency medical service) left with resident at 11.05 am and to the nearest ER (Emergency Room). The following documents were sent with resident; face sheet, medication and treatment list, bed hold policy, recent lab results, physician progress note, code status, Report given to ER nurse... RP (representative) notified ..."

02/02/22 at 7:00 AM [Social Work Progress Note] "Late Entry: [Resident #132] was transferred to Acute Care Hospital ...with the bed hold and fair hearing forms attached."

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During a face-to-face interview on 04/11/22 at 2:45 PM with Employee #10 (Director of Social Services), she stated, "When a resident is transferred to the hospital we contact the family by phone, we complete a notice of transfer and give it to the resident's representative. We also send the forms to the Ombudsman."

It should be noted that Employee #10 was not able to provide documented evidence that Resident #132's representative(s) was provided a written copy of the reason of transfer on 02/22/22.

1C. Resident #406 was admitted to the facility on 01/28/22 with multiple diagnoses including, End Stage Renal Disease, Alcohol Abuse Uncomplicated and Hemiplegia and Hemiparesis Following Cerebral Infarction.

Review of Resident #406's medical record revealed, an Admission MDS dated 02/03/2022, where facility staff coded a BIMS summary score of "15", indicating intact cognition.

02/10/22 at 8:13 AM [Social Work Progress Note] "[Resident #406] was transferred to [hospital name]..."

The medical record lacked documented evidence that Resident #406 or their representative(s) were provided a written copy of the reason of transfer on 02/10/22.

During a face-to-face interview conducted on 04/12/22 at 10:54 AM, Employee #10 (Director of Social Work) she acknowledged the finding.

2. Facility staff failed to provide written notification

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F 623	Continued From page 109	F 623		8/24/22

to Resident #82's, #233's and #404's representative(s) of room relocation.

2A. Resident #82 was admitted to the facility on 09/15/21with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss.

Review of Resident #82's medical record revealed:

A Quarterly Minimum Data Set (MDS) dated 11/23/21 that showed facility staff coded a Brief Interview for Mental Status (BIMS) summary score, "00", indicating severe cognitive impairment.

01/27/22 [Physician's Orders] "Relocate resident to room 420A"

Review of Resident #82's electronic and paper health record lacked documented evidence to show that Resident #82's representative(s) were provided written notification of or the reasons for the relocation.

During a face-to-face interview conducted on 04/04/22 at 12:14 PM, Employee #11 (4th Floor Social Worker) acknowledged the finding and stated, "I don't see any other written notice for the move to room 420 A."

2B. Resident #233 was admitted to the facility on 05/26/21 with diagnoses including Diabetes Mellitus with Diabetic Neuropathy, Chronic Kidney Disease Stage 4, and Cerebral Infarction Due to Unspecified Occlusion or a Stenosis of Unspecified Cerebellar Artery.

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F 623	Continued From page 110	F 623		8/24/22

A Quarterly Minimum Data Set dated 03/16/22 facility staff coded Resident #233 with Brief Interview for Mental Status Summary Score of "15," indicating that the resident was cognitively intact.

A review of Resident #233's medical record revealed:

01/01/22 at 9:53 AM [Activities Note -In-house Transfer]: "[Resident #233's] was relocated from room [insert room #] to [room on the fifth floor] as a precautionary measure related to Covid-19."

Review of Resident #233's medical record lacked documented evidence to show that Resident #233 or their representative(s) were provided written notification of the reasons for the relocation.

During a face-to-face interview on 04/06/22 at 12:51 PM, Employee #13 (Social Worker) acknowledged the finding.

2C. Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack.

Review of Resident #404's medical record revealed, a Quarterly MDS dated 12/16/21 that showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment.

01/10/22 [Physician's Order] "Relocate resident to room 420D..."

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F 623	Continued From page 111 Review of Resident #404's medical record lacked documented evidence to show that Resident #404's representative(s) was provided written notification of or the reasons for the relocation. During a face-to-face interview conducted on 04/04/22 at 12:14 PM, Employee #11 (4th Floor Social Worker) acknowledged the finding and made no further comment.	F 623		8/24/22
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625	F 625 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 132 was assessed from head to toe on 4/26/22 by Unit Manager, resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident will be updated and provided a copy of the bed hold days by 8/24/2022. Resident #151 was assessed from head to toe on 4/26/2022 by Unit Manager. Resident suffered no negative outcomes. MD/RP notified on 4/26/22 Resident / Responsible party will be updated on the bed hold policy by 8/24/22	

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F 625	Continued From page 112 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 105 sampled residents, facility staff failed to provide Resident #132 and Resident #151 or their representative(s) with written information that specified the bed-hold policy. The findings include: Review of the facility policy entitled, "Transfer or Discharge, Emergency Care" dated 03/2022 documented, "...The Social Worker/Designee during hospital transfer...will ensure that the resident and responsible party is notified verbally or by telephone or in writing of how many bed hold days the resident has..." 1. Resident #132 was readmitted on 02/11/22 from a [Local hospital] with diagnoses that included: Urinary Tract Infection (UTI), Alzheimer's, Dementia, Epilepsy and Muscle Weakness (Generalized). A review of the Quarterly Minimum Data Set (MDS) for Resident #132 dated 02/17/22 revealed that facility staff coded the resident with a Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating that the resident had severely impaired cognition. A review of Resident #132's medical record revealed: 02/02/22 11:44 AM [Nurses Notes]: "At 10.15 AM resident was noted with crackles, chest	F 625	IDENTIFICATIONOF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. Licensed Social Services employees /Designee will conduct house wide audit to ensure that the responsible parties are notified or provided with a copy of the bed hold policy when a resident is out of the facility and update them of the bed hold days. Any issues found will be corrected by 8/24/22	8/24/22

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F 625	Continued From page 113 congestion, labored breathing and SOB with sat at 88%... 911 called and arrived to the unit at 10.40 AM. After assessment. EMS left with resident at 11.05 AM and to the nearest ER (Emergency Room). The following documents were sent with resident; face sheet, medication and treatment list, bed hold policy, recent lab results, physician progress note, code status, Report given to ER nurse... RP (resident representative) notified ..." 02/02/22 at 1:24 PM [Nurses Note]: "Follow up placed call to [Name of Local Hospital] regarding resident sent out to the ER earlier today, writer spoke to ER staff and was informed that resident will be admitted and just waiting for a bed. RP (resident representative] and MD [Medical doctor] updated." 02/03/22 at 7:00 AM [Social Work Progress Note] Late Entry: "[Resident #132] was transferred to Acute Care Hospital ...bed hold and fair hearing forms attached." Review of the medical record lacked documented evidence that Resident #132 or their representative(s) were notified verbally, by telephone or in writing of how many bed hold days the resident had when the resident was transferred to the ER on 02/02/22. During a face-to-face interview on 04/11/22 at 2:45 PM, Employee #10 (Director of Social Services) acknowledged the finding and stated, "When a resident is transferred to the hospital, we contact the family by phone, we complete a notice of transfer and bed hold policy and give it to the resident and or/resident's representative..."	F 625	F625 MEASURES TO PREVENT RECURRENCE: Training will be provided by Staff Educator/ Designee to the Licensed Social Services employees on the importance of providing written or telephone notification to responsible parties when the resident is transferred to the hospital by 8/24/2022. Repeat training will be provided as needed. Admission Coordinator will ensure that bed hold days are accurate on the 6-108 presented to him/ her by the Licensed Social services employees. Also, that the responsible party has a copy of the bed hold policy. Any issues found will be addressed by 8/24/22. Licensed Social services employees will ensure that there is documentation on the bed hold policy and that a telephone call or written document was presented to the responsible party. Any issues found will be corrected by 8/24/22	8/24/22

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F 625	Continued From page 114 It should be noted that Employee #10 was not able to provide documented evidence that Resident #132's representative(s) was provided a written copy of the bed hold days the resident had when the resident was transferred to the ER on 02/02/22. 2. Resident #151 was admitted to the facility on 10/22/20, with multiple diagnoses that included: Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia. An Admission Minimum Data Set dated 12/08/21, showed that facility staff coded Resident #151 with a Brief Interview for Mental Status summary score of "07", indicting severe cognitive impairment. A progress note dated 12/30/21 at 6:04 AM [Nursing Supervisor Note] documented, "... At approximately 12:00 AM ... writer was called by staff to go to the Lobby as police was requesting some demographic information on the resident ... The resident attempted to hit one of the officers while they were attempting to talk to him. The officers then handcuffed resident and took him to ... emergency psychiatric [hospital] evaluation and triage..." Review of Resident #151's medical record lacked documented evidence to show he or his legal guardian were notified verbally, by telephone or in writing of how many bed hold days the resident had when the resident was transferred to the ER on 12/29/22. During a face-to-face interview conducted on 04/14/22 at 1:30 PM, Employee #11 (4th Floor Social Worker) acknowledged the finding and	F 625	MONITORING CORRECTIVE ACTION: Licensed Social Services Director will audit the charts of all residents who are transferred to the hospital to ensure that the responsible party is notified of the bed hold policy and bed hold days the resident has and that there is adequate documentation to justify that information was provided. This will be ongoing. The Director of Nursing will validate that the responsible party was notified or was presented with the bed hold policy when the resident was transferred to the hospital. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately, and report presented to QAPI committee.	8/24/22

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F 625	Continued From page 115 stated that no notice of bed-hold was provided.	F 625		8/24/22
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for 2 (two) of 105 sampled residents, the facility's staff failed to ensure that Resident #181's Quarterly Minimum Data Set (MDS) dated 03/01/22 and Resident #188's Quarterly Minimum Data Set (MDS) dated 03/03/22 were completed 14 days after the assessment reference date. The findings include: 1. Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease. Review of the resident's Quarterly MDS dated 03/01/22 showed Resident #181 had an assessment reference date of 03/01/22, which made the MDS required completion date 03/15/22. Sections G (Functional Status), GG (Functional Abilities and Goals) and Z (Assessment Administration) showed that Employee #19 (Regional MDS Coordinator) completed these sections on 03/22/22. Additionally, Section Z0500, "RN Assessment Coordinator's Signature and Date to verify completion" was left blank.	F 638	F638 CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #181 was assessed by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/RP updated. This deficiency cannot be retroactively corrected. Resident #188 was assessed by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/RP updated. This deficiency cannot be retroactively corrected. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. MDS Coordinators will conduct house wide audit to ensure that quarterly assessments are completed within the required 14 days of the assessment reference date and that an RN has signed to verify completion of assessment. Any issues found will corrected by 8/24/22.	

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F 638	Continued From page 116 2. Resident #188 was admitted to the facility on 01/21/22 with the following diagnoses: Diabetes Mellitus, Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, Altered Mental Status, Visual Hallucinations, Restlessness and Agitation, Syncope and Collapse Review of Resident #188's Quarterly Minimum Data Set (MDS) dated 03/03/22 revealed an assessment reference date of 03/05/22. Based on the MDS assessment reference date, the required completion date for the MDS was 03/17/22. Section Z0500, "RN Assessment Coordinator's Signature and Date to verify completion" was left blank. The evidence showed that facility staff failed to complete the MDS within the required 14 days (03/17/22). During a face-to-face interview on 04/11/22 at 12:49 PM, Employee #19 (Regional MDS Coordinator) acknowledged the findings and stated that she did not sign the MDS completion dates for Residents #181 and #188.	F 638	MEASURES TO PREVENT RECURRENCE: Training will be provided by Regional MDS coordinator to the MDS team members to always ensure that the quarterly assessments are completed within the required 14 days after the ARD. Any issues found will be completed immediately. The Director of Quality Assurance / Designee will validate that all quarterly assessments are completed in a timely manner and that an RN has signed to verify completion. Any issues found will be corrected by 8/24/22 MONITORING CORRECTIVE ACTION: The MDS Lead staff member will ensure that quarterly assessments are completed by the MDS team correctly and that an RN signs and date the assessment to verify completion. This audit will be done weekly x4, then monthly x4. Findings will be corrected immediately and reported to QAPI committee.	8/24/22
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for five (5) of 105 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS). Residents' #50, #155, #160, #183 and	F 641		

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F 641	Continued From page 117 #502. The findings include: 1. Facility staff failed to code Resident #50's MDS to reflect the need of 2 person's physical assist. Resident #50 was admitted to the facility on 06/26/14 with multiple diagnoses that included: Morbid Obesity, Anxiety Disorder, Mood Affective Disorder and Major Depressive Disorder. Review of Resident #50's medical record revealed the following: 01/30/20 (Revision date) [Care Plan] "[Resident #50] has an ADL (activities of daily living) self-care performance deficit r/t (related to) limited ROM (range of motion), limited mobility, morbid obesity ... the resident requires 2 staff participation to reposition and turn in bed, the resident requires total assistance with personal hygiene care ..." 11/16/20 (Creation Date) [Care Plan] "Alleged abuse ... 2 CNAs (Certified Nurse Aides) to provide ADL care all shift ..." 11/17/20 [Physician's Order] "2 CNAs to provide ADL care all shift" Review of Resident #50's Quarterly MDS dated 09/24/21 showed that facility staff coded "one person physical assist" for ADL assistance with personal hygiene. During a face-to-face interview conducted on 04/19/22 at 12:26 PM with Employee #19 (Regional MDS Coordinator), she acknowledged	F 641	F 641 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS. Resident # 50 was assessed from head to toe by Unit Managers on 4/26/2022, resident suffered no negative outcome. MD/RP notified on 4/26/22. Coding for MDS is two persons assist for ADL. Resident # 155 was assessed from head to toe by Unit Manager on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. MDS coding reflects his desire to go home. Resident # 183 was assessed from head to toe on 4/26/22 by Unit Manager, resident suffered no negative outcome. MD/RP notified on 4/26/22 MDS coding will reflect history of multiple falls by 8/24/22 Resident #502 discharge home 6/2/22 Resident #160 was assessed from head to toe on 4/26/2022 by Unit Manager. Resident suffered no negative outcome. MD/RP notified on 4/26/22. MDS Coding will reflect rejection of care by 8/24/22 Resident # 502 was discharged home on 6/2/22	8/25/22

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F 641	Continued From page 118 the finding and made no further comment. 2. Facility staff failed to accurately code Resident #155's MDS to reflect his desire to return to the community. Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses that included: Dysphagia, Oropharyngeal Phase, Unspecified Lack of Coordination, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Dominant Side. Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, showed that facility staff coded a (Brief Interview for Mental Status (BIMS) Summary Score "05", indicating severe cognitive impairment. In Section Q (Participation in Assessment and Goal Setting), "Resident participated in assessment "1" meaning yes Q0400 (Discharge Plan): Is active discharge planning already occurring for the resident to return to the community? "No". Does the residents clinical record document a request that this question be asked only on comprehensive assessments? "No" Q0500 (Return to Community), Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community? "No" Q0500 (Resident's preference to Avoid being asked question Q0500B again) Does the resident ..want to be asked about returning to the	F 641	F641 IDENTIFICATION OF OTHERS WITH THE POTENTAIL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. MDS coordinators will conduct weekly house wide audit to ensure that MDS staff are coding correctly for residents with two persons physical assist with AD resident with the desire to return to the community residents rejecting care, residents with history of fa and residents with diagnosis of dialysis are accurately coded. Any issues found will be correct by 8/24/22	8/24/22

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F 641	Continued From page 119 community on all assessments? "Yes" Q0600 (Referral), Has a referral been made to the local contact agency? "No" Review of Care Plan meeting note on 03/04/20 at 12:13 PM showed, " ...care plan meeting was held today 3/4/2020. [Resident #155] and his...RP (representative) was present at the meeting. SW [social worker] reported that he is a full code and long-term care status. The SW is working with [Name] to locate appropriate housing for him but until that time he will remain in long term care." Review of the Social Work Progress Notes revealed the following: 06/16/21 at 7:18 AM, "Information sent to the Office on aging for [Resident #155] to be considered for transition back to the community. The social worker will follow up with the family" 06/16/21 at 8:42 PM, "The care plan/IDT (Interdisciplinary team) meeting was held today for [Resident #155]. His new RP [Representative] soon to be Power of Attorney and mother of his child ... was present at meeting..." 07/23/21 at 2:50 PM, "The SW return [Resident Representative] call concerning [Resident #155] She stated that he called her and was asking to leave here because he was tired of being here..." 12/29/21 at 5:11 PM, "... the Ombudsman called the SW and the Supervisory SW stated that [Resident's sister] felt as if the SW and the transition worker were holding up the process towards [Resident #155] going into [Name of Assisted Living Facility]."	F 641	F641 MEASURES TO PREVENT RECURRENCE: Training will be provided by Staff Educator/ Regional MDS coordinator to the MDS staff on the importance of proper coding by 8/24/2022. MDS coordinators will conduct a check on coding to ensure that they are coding correctly for residents who are two persons assist, those on dialysis and those wishing to return to the community. Any issues found will be corrected by 8/24/22. Unit Manager and Supervisors will ensure that CNA‘s are documenting ADL's accurately daily A resident who requires two persons assist will be consistent with the MDS documentation and coding. Any issues found will be addressed by 8/24/22. ADON/Designee will conduct audits to ensure that the residents who are non-compliant with care are documented and that MDS is capturing and coding this aspect correctly weekly.Any issues found will be corrected by 8/24/22.	8/24/22

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F 641	Continued From page 120 The evidence showed that Resident #155 expressed a wish to be discharged to the community, however, facility staff failed to accurately code the MDS to reflect this desire. During a face-to-face interview conducted on 04/18/22 at 1:30 PM, with Employee #18 (MDS Coordinator) she stated, "The social services fills out that section (Section Q)." During a face-to-face interview conducted on 04/18/22 at 3:00 PM with Employee #13 (5th Floor Social Worker), she acknowledged that the MDS for Resident #155 was not accurately coded and stated, "I fill out the section based on what the team has agreed. This is a systemic issue." 3. Facility staff failed to accurately code the MDS to reflect Resident #160's rejection of care. Resident #160 was admitted to the facility 02/20/12, with multiple diagnoses that included: Morbid Obesity, Diabetes Mellitus, Major Depressive Disorder and Anxiety. Review of Resident #160's medical record revealed the following: 02/25/22 at 12:08 PM [Daily Behavior Documentation] "Resident exhibits the following ... Refuses Medications. Refuses ADL Care. Refuses Treatment. Refuses Therapeutic Activities. Behaviors are constant. Behavior problems leads to issues with care." 02/25/2022 at 12:54 PM [Care Plan Meeting Note] "Care conference with resident's daughter	F 641	Unit Managers/ Designee will ensure that nurses report all falls and that MDS is coding residents with falls accurately. Findings will be corrected by 8/24/22 Rehab team will ensure that they notify the MDS team if the resident is two-person physical assist with ADL care as a triple check follow up exercise. Any issues found will be corrected by 8/24/22.	8/24/22

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F 641	Continued From page 121 via phone... At times she is noncompliant with medications..." 02/26/22 at 2:44 PM [Daily Behavior Documentation] "Resident exhibits the following ... Refuses Treatment. Refuses Therapeutic Activities. Behaviors are constant. Behavior problems leads to issues with care." A 5-day MDS dated 02/26/22 showed facility staff coded a BIMS summary score "06", indicating severe cognitive impairment and in Section E (Behavior) that no rejection of care behaviors occurred. During a face-to-face interview conducted on 04/11/22 at 10:03 AM, Employee #18 (MDS Coordinator) acknowledged the finding and stated, "Section E (Behavior) is completed by social services." 4. Facility staff failed to ensure Resident #183's MDS was accurately coded to reflect the resident's history of falls. Review of a Facility Reported Incident dated 10/14/21 documented, "... fall was in the facility van ..." Resident 183 was admitted to the facility on 03/20/14 with diagnoses that included Diabetes Mellitus Type 2, End Stage Renal Disease, and Acquired Absence of Left Leg Below Knee. Review of the physician's orders showed the following: 10/21/21 "Yellow star fall program (yellow star indicates resident is a high risk for falls) ..."	F 641	F 614 MONITORING CORRECTIVE ACTION: Rehab Director and MDS lead will conduct audits to ensure that all coding is done accurately. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately, and report presented to QAPI committee.	8/24/22

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F 641	Continued From page 122	F 641		8/24/22

Review of the care plan revised on 10/19/2021 with a focus area of, "[Resident #183] had an actual fall with no injury unsteady gait on 4/1/2019, 6/4/2019 ... had a fall with injury to the left knee ... 7/14/2020 had a fall without injury, fell on 10/14/21 on the van without injury."

Review of the Quarterly MDS dated 11/22/21, revealed in section J (Health Conditions) facility staff coded the following:

J1700 - "Fall History on Admission/Entry or Reentry" was left blank

Review of the Quarterly MDS) dated 02/22/22, revealed in section J (Health Conditions), facility staff coded:

J1700 - Did the resident have a fall anytime in the last month prior to admission/entry or reentry, facility staff coded "0", indicating no; Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry?, facility staff coded "0", indicating no

J1800- Has the resident had any falls since admission/entry or reentry or the prior assessment ...whichever is most recent?, facility staff coded "0", indicating no.

The evidence showed that facility staff failed to accurately code Resident #183's MDS on 11/22/21 and on 02/22/22.

During a face-to-face interview conducted on 04/08/22 at 12:35 PM, Employee #18 (MDS Coordinator) acknowledged the finding and stated, "I did not understand the questions being asked."

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F 641	Continued From page 123 5. Facility staff failed to accurately code Resident #502's MDS for dialysis. Resident #502 was admitted to the facility on 03/17/22 with multiple diagnoses including End-Stage Renal Disease, Anemia, Chronic Pancreatitis, Chronic Viral Hepatitis C, Hypertension, Peripheral Vascular Disease and Hyperlipidemia. Review of Resident #502's medical record revealed the following: 03/17/22 [Physician's Order] "Dialysis: Tuesday, Thursday, Saturday..." 03/17/22 [Quarterly MDS], showed that facility staff coded the following: In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "15", indicating intact cognitively. In Section O (Special, Treatments Procedures and Programs), O0100 under other ... Dialysis, facility staff coded "1" ... indicating not on Dialysis. The evidence showed that facility staff failed to accurately code Resident #502's MDS to reflect that Resident #502 was on Dialysis. During a face-to-face interview conducted on 04/19/22 at 1:40 PM, Employee #19 (MDS Coordinator) acknowledged the finding and stated, "I will review this (MDS assessment)."	F 641		8/24/22
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		

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F 655	Continued From page 124 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655	F 655 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS. Resident #3 was discharge home 3/29/2022 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Clinical care coordinator/ Designees will conduct house wide audit to ensure that residents responsible parties are provided a summary of the baseline care plan. Findings will be addressed by 8/24/22	8/24/22

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F 655	Continued From page 125 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, for one (1) of 105 sampled residents, facility staff failed to provide Resident #3's representative with a summary of the baseline care plan. The findings include: Facility staff failed to provide Resident #3's representative with a summary of the baseline care plan. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of the Resident #3's medical record lacked documented evidence that the summary of the base-line care plan was provided to Resident #3's representative(s). During a telephone interview on 04/12/22 starting at 11:35 AM, the resident's granddaughter stated that neither she nor her mother (responsible party) ever received a copy of the baseline a care plan or attended a care plan meeting for Resident #3. During a face-to-face interview on 04/13/22 at 11:47 AM, Employee #11 (4th Floor Social	F 655	F 655 MEASURES TO PREVENT RECURRENCE: Training will be provided by Staff Development / Designee to all licensed clinical team members to ensure that a summary of the resident's baseline care plan is provided to the responsible party by 8/24/2022. Licensed Social services team will ensure that a copy of a summary of a resident's care plan and baseline care plan are given to the resident's responsible party. Findings will be addressed by 8/24/22. Licensed clinical team members (RN/LPN) will ensure that there is documentation in place to show that a copy of a resident's baseline care plan was provided to the responsible party. Any issues found will be corrected by 8/24/22. Licensed clinical team members will ask the responsible party during an IDT meeting if they need a copy of the baseline care plan, current medication list and medical diagnosis. If yes, it will be presented to them. Any issues found will be corrected by 8/24/22.	8/24/22

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F 655	Continued From page 126 Worker) stated that Resident #3's representative did not receive a summary of his base-line care plan and had not had a care plan meeting since his admission on 12/21/21.	F 655	MONITORING CORRECTIVE ACTIONS: DON/Designee will audit residents' chart to ensure that the responsible party was given a copy of the resident' s baseline care plan. Findings will be corrected immediately. This audit will be conducted weekly x4, then monthly x3, report will be presented to QAPI committee.	8/24/22
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered 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	F 656		

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F 656	Continued From page 127 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for eight (8) of 105 sampled residents, facility staff failed to develop and/or comprehensive care plans with measurable goals, timeframes and approaches to address resident care concerns (Stoma Site Care, 2 CNAs for ADL care, assistance with dentures, indwelling urinary catheter, speech deficit, new diagnosis of chest pain, behavior of urinating on the bathroom floor, refusal of care and complaints of chest pain. Residents' #3, #50, #81, #126, #132, #155, #180 and #403. The findings include: Review the facility's policy entitled, "Interdisciplinary Team Meeting (Care Plan Meeting)" revised 03/2022 documented, "... It is the policy of [Facility Name] to develop and implement person-centered care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care..." 1. Facility staff failed to include interventions to care of Resident #3's stoma site. Resident #3 was admitted to the facility on	F 656	F 656 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 3 was discharge home on 3/29/2022 Resident #50 was assessed from head to toe by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/ RP notified on 4/26/22. Care plan implementation for two persons assist with ADL will be updated immediately but no later than 8/24/22. Resident # 126 was assessed from head to toe on 4/26/2022,by Unit Manager, resident suffered no negative outcome. MD/RP notified on 4/26/22. Care plan to address two person assist with transfer will be updated immediately but no later than 8/24/22. Resident # 132 was assessed from head to toe on 4/26/2022,by Unit Manager, resident suffered no negative outcome. MD/RP notified on 4/26/22. Comprehensive care plan for indwelling catheter will be put in place immediately but no later than 8/24/22. Resident # 155 was assessed by Unit Manager on 4/26/2022, resident suffered no negative outcome.MD/RP notified on 4/26/22. Care plan to address speech deficit will be in place immediately but no later than 8/24/22.	8/25/22

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F 656	Continued From page 128 12/01/21 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. An Admission Minimum Data Set (MDS) dated 12/03/21 showed that facility staff coded the following: In Section I (Active Diagnoses), cancer, malignant neoplasm of laynx (sp), surgical aftercare following surgery of respiratory system, tracheostomy status and malignant neoplasm of supraglottis. In Section O (Special Treatment, Procedures, and Programs) - the resident was coded for receiving tracheostomy care and speech therapy services. The resident was not coded for respiratory therapy services. Review of Resident #3's medical record revealed the following: 11/30/21 [Hospital Discharge Summary] documented, "laryngeal cancer s/p (status post) total laryngectomy, laryngectomy tube 10/27/21...Do not occlude stoma in neck, the patient is a neck breather ..." 12/02/21 at 3:31 PM [physician progress note] documented, "He was recently hospitalized secondary to laryngeal cancer with tracheostomy requirement ...Past medical history ...large laryngeal mass, status post total laryngectomies ..." 12/04/21 [physician's order] instructed, "Do not occlude stoma in neck. The [patient] is neck	F 656	Resident #180 was assessed from head to toe by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/ RP notified on 4/26/22. Comprehensive care plan to address behavior of urinating on the bathroom floor, smearing bathroom with feces will be updated immediately but no later than 8/24/22. Resident #81 was assessed for denture use by unit manager on 4/26/22 resident suffered no negative outcome. Care plan for assistance with denture use will be put in place immediately but no later than 8/24/22. CNA's will be educated to ensure residents with dentures have them on during meals. C N A 's are also encouraged to assist resident with wearing of dentures during meals as needed. Resident #403 was sent to the hospital on 3/18/2022 and she did not return to the facility.	8/24/22

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F 656	Continued From page 129 breather." 02/07/22 [Physician's order] instructed, "Please clean and remove crusting from in and around to stoma BID (two-times-a day) with moist gauze and sterile (stoma should not be covered). Review of the comprehensive care plan with an initial date of 12/04/21 showed the following: Focus Area-[resident's name] has lary tube r/t (related to) laryngeal cancer. Goal-[resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed... Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22. During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated that he included interventions to address Resident #3's use of a lary-tube, but he did not include interventions to address the resident's stoma site care. 2. Facility staff failed to implement the care plan intervention of having two (2) CNAs (Certified Nurse Aides) for activities of daily living assistance (ADL) for Resident #50. Review of a Facility Reported Incident (FRI) received on 11/22/21, documented, "...allegation made by [Resident #50] on 11/15/21 that at 11:30	F 656	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED;' All residents residing in the facility have the potential to the affected. Licensed clinical team members (LPN/RN) conducted house wide audit on 4/22/2022 to ensure that the residents have a person-centered comprehensive care plan, that residents with dentures have them and if need be, assistance is provided with wearing the dentures, and that residents with non-compliant behavior has documentation on the implementations in place. Any issues found will be corrected by 8/24/22.	8/24/22

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F 656	Continued From page 130 AM, a CNA ... hit her 6 times on her left knee with a bar of soap wrapped in a towel ..." The CNA ...was interviewed; she said she went to resident's room at 9:20PM and asked her if she was ready to be changed and Ms. Lambright said yes. The CNA said she called the nurse to come and assist her because resident is two persons assist, but resident refused two persons to provide care to her; the CNA then said she proceeded to provide incontinent care to resident ..." Resident #50 was admitted to the facility on 06/26/14 with multiple diagnoses that included: Morbid Obesity, Anxiety Disorder, Mood Affective Disorder and Major Depressive Disorder. Review of Resident #50's medical record revealed the following: A Quarterly MDS dated 09/24/21 showed that facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of "13", indicating intact cognition. 01/30/20 (Revision date) [Care Plan] "[Resident #50] has an ADL self-care performance deficit r/t (related to) limited ROM (range of motion), limited mobility, morbid obesity ... the resident requires 2 staff participation to reposition and turn in bed, the resident requires total assistance with personal hygiene care ..." 11/16/20 (Creation Date) [Care Plan] "Alleged abuse ... 2 CNAs to provide ADL care all shift ..." 11/17/20 [Physician's Order] "2 CNAs to provide ADL care all shift"	F 656	F 656 MEASURES TO PREVENT RECURRENCE: In-service will be provided to all licensed clinical staff members, Rehab staff and C N A ‘s by staff educator / Designee to ensure that a person-centered care plan for a resident is implemented as indicated by 8/24/2022 Unit Managers and Supervisors will audit resident clinical records to ensure that they have a revised person-centered care plan in place on a weekly basis Any issues found will be corrected by 8/24/22. ADON/Designee will audit residents clinical record to ensure that the nurses are revising and updating resident’s person- centered care plans. Any issues found will be corrected by 8/24/22.	8/24/22

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F 656	Continued From page 131 11/16/21 at 9:40 AM [Nurses Note] "At around 9.30 PM (11/15/2021), the CNA ... called the writer to room 229 B because [Resident #50] was refusing her to finishing cleaning her. Upon entering the room, the writer found [Resident #50] shouting, cursing the CNA alleging that the CNA hit her on the thigh. The writer assessed the resident and there were no signs of hitting nor was she in any pain or distress ...The writer released the CNA and called CNA ... to help finish cleaning the resident ..." The evidence showed that facility staff failed to implement the care plan intervention of having two CNAs perform for ADL care of Resident #50 on 11/15/21 during the evening shift (3:00 PM to 11:00 PM). During a face-to-face interview conducted on 04/12/22 at 10:00 AM, Employee #7 (Clinical Coordinator) acknowledged the finding and made no further comment. 3. Facility staff failed to develop a care plan to address Resident #81's include assisting Resident #81 with applying her dentures at mealtimes. During an observation on 03/30/22 at approximately 1:30 PM, Resident #81 the resident was observed with her lunch tray. When asked if she liked the food at the facility, the resident reported that the food in the facility was okay, but she wanted to wear her dentures when she eats. The writer asked if her dentures were with her in the facility and she stated, "Yes." Resident #81 was admitted to the facility on 08/22/18 with diagnoses including Cerebral	F 656	F656 Continuation of measures to prevent recurrence: Unit managers/ Designee will ensure that residents with dentures are assessed for proper use of dentures on a weekly basis. Staff will assist residents who need help with wearing dentures. Any issues found will be corrected by 8/24/2022. CNA ‘s will ensure that residents with dentures have their dentures on at mealtime during their shift .Any issues found will be corrected immediately and ongoing till 8/24/22. Unit managers will ensure a care plan for dentures is in place for residents wearing dentures weekly. Any issues found will be corrected by 8/24/22. Unit managers will ensure that residents with two persons physically assist with transfer have a care plan in place and implementations are followed weekly. Any issues found will be corrected by 8/24/22. Charge nurses will ensure that residents with indwelling catheter have a comprehensive care plan in place and that the interventions are implemented as indicated weekly. Any issues found will be corrected by 8/24/22.	8/24/22

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F 656	Continued From page 132 Vascular Accident (CVA), Human Immuno-Deficiency Virus (HIV), Diabetes Mellitus, and Cognitive Communication Deficit. A review of the Quarterly Minimum Data Set (MDS) for Resident #81 dated 03/06/22 revealed that facility staff coded the resident in the following manner: In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "03," indicating that the resident had severely impaired cognition. In Section G (Functional Status), ADL assistance: for personal hygiene, the resident was totally dependent and required physical assistance from one staff person. For eating/meals, the resident required limited assistance from one staff person. A review of Resident #81's medical record revealed: 08/23/18 (Date initiated) [Care Plan focus area]: [Resident #81] at risk for ADL Self-care deficit as evidenced by weakness to right side related to CVA. Interventions included: Assist with daily hygiene, grooming, dressing, oral care, and eating as needed ...Encourage to participate in self-care ...." "Focus: [Resident #81] at risk for dental or oral cavity health problem related to health condition (CVA). [Resident #81] is edentulous. Interventions included assist with oral hygiene as needed ...." 09/02/21[Denture Quality Assurance Checklist] documented: 1) Patient is satisfied with fit, 2) Patient is satisfied with esthetics, 3) Name is in the denture, 4) Denture kit given ... "signed by	F 656	Supervisors will ensure weekly that care plans are in place for residents with speech deficit and that the intervention are implemented as indicated. Any issues found will be corrected by 8/24/22. Unit Managers will ensure that residents with behavior of urinating on the bathroom floor, smearing the bathroom with feces have a care plan for such behavior in place. Such resident will be assessed for toileting program weekly. Any issues found will be addressed by 8/24/22.	8/24/22

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F 656	Continued From page 133 Unit Nurse and Dentist." 09/02/2021 [Dentist Note]: "...Patient satisfied with fit and esthetics ..." 10/29/21 at 8:00 AM [Physician's Order]: "ST (Speech Therapy) Strategies sit upright, alternate small bites/sips at slow rate, reduce distractions, check for pocketing, assist with cutting up meat, clear to cough/throat clear." 02/06/22 at 7:52 PM [Physician's Order]: "CHO (Consistent Carbohydrate Diet) regular texture, thin liquid consistency." During a second observation on 04/01/22 at 1:45 PM, Resident #81 was seen with her lunch tray. The resident was not wearing her dentures. When asked about the dentures, Resident #81 stated, "No one put them in for me." Review of the comprehensive care plan lacked documented evidence that facility staff included an intervention to assist Resident #81 with putting in her dentures including at mealtimes. During a face-to-face interview on 04/01/22 at 1:51 PM, Employee #2 (Director of Nursing/DON) acknowledged that Resident #81's comprehensive care plan did not include assisting the resident with putting in her dentures at mealtimes and that she would update the care plan. 4. Facility staff failed to develop a care plan to address Resident #126's needing 2 person physicl assist with tranfers. Review of the FRI (Facility Reported Incident)	F 656	Supervisors will ensure weekly that care plans are in place for residents with speech deficit and that the intervention are implemented as indicated. Updated provided during validation meeting to supervisors. Any issues found will be corrected by 8/24/22. Unit Managers will ensure that residents with behavior of urinating on the bathroom floor, smearing the bathroom with feces have a care plan for such behavior in place. Such resident will be assessed for toileting program weekly. Any issues found will be addressed by 8/24/22.	8/24/22

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dated 12/27/21 documented " ...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the 1/4 side rail; resident sustained a laceration on the upper lateral right leg; resident scratched her right leg at the edge of the 1/4 side rail. Writer was made aware of the incident; writer assessed the wound "

Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Heart Failure, Presence of Right Artificial Knee Joint, and Other Lack of Coordination.

Review of the Admission Minimum Data Set (MDS) dated 11/17/21, revealed that the facility staff coded the following:

In Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "11", indicating moderately impaired cognition.

In Section G (Functional Status): Transfer "Extensive assistance" requiring "Two-person physical assist"

Review of the nursing progress note dated 12/23/21 at 11:50 AM documented, "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the ¼ side rail ..."

Review of Resident #126's care plan revealed that facility staff failed to develop a comprehensive care plan to address the resident ' s need for two-person physical assist with transfers.

During a face-to-face interview conducted on

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04/20/22 at 10:45 AM, Employee #58 (Certified Nurse Aide) stated, "It was just me who transferred her [Resident #126] to the bed (on 12/23/21). Nobody was there, only me."

5. Facility staff failed to develop a comprehensive care plan to address Resident #132's use of an indwelling urinary catheter.

During an observation on 04/07/22 at approximately 3:45 PM, Resident #132 was observed with an indwelling urinary catheter with a urine collection bag.

Resident #132 was readmitted to the facility on 02/11/22 with diagnoses that included: Urinary Tract Infection, Alzheimer's, Dementia, Epilepsy and Muscle Weakness (Generalized).

A review of the Quarterly Minimum Data Set (MDS) for Resident #132 dated 02/17/22 revealed that facility staff coded the resident in the following manner:

In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating that the resident had severely impaired cognition.

In Section H (Bowel and Bladder) H0100 Appliances: Indwelling catheter

A review of Resident #132's medical record revealed:

01/06/22 (Date initiated) [Care Plan focus area]: "[Resident #132] has urinary incontinence related to dementia, impaired mobility ...."
02/11/22 at 11:11 PM [Nurses Note - Late Entry]:

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"...resident, readmitted in evening.. Head-to-toe assessment done: Skin is warm to touch, and patient noted with Foley catheter ...Resident is stable."

04/04/22 at 2:48 PM [Nurses Note]: "...Foley catheter intact and draining clear urine."

Further review of Resident #132's medical record lacked documented evidence that facility staff developed a comprehensive care plan to address the resident's use of an indwelling urinary catheter.

During a face-to-face interview on 04/07/22 at 3:48 PM with Employee #47 (Licensed Practicing Nurse/LPN), she acknowledged that Resident #132's comprehensive patient-centered plan did not include the resident's indwelling urinary catheter care, and she would make sure the care plan was updated.

6. Facility staff failed to develop a comprehensive person-centered care plan that addressed Resident #155's speech deficit and the resident's complaint of chest pains which resulted in an emergency room visit.

Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses that included: Dysphagia, Oropharyngeal Phase, Unspecified Lack of Coordination, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Dominant Side.

Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, showed that facility staff coded the following:

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In section B (Hearing, Speech, and Vision), Speech Clarity "1" "Unclear Speech"

Makes self-understood "1-Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time."

Ability to understand others "1- Usually understands"

In Section C (Cognitive Patterns) BIMS (Brief Interview for Mental Status) Summary Score "05" indicating severe cognitive impairment.

A.Review of the document titled "Speech Therapy SLP Evaluation and Plan of Treatment" dated 11/02/21 and signed by the residents' providers, revealed the following: In the section titled "Diagnoses" "Cognitive communication deficit, Dysphagia, Oropharyngeal phase"

In the section titled "Receptive/Expressive Language & Communication Abilities" "Verbal Expression =50% ...making needs known= 50%, Conversation = 50%, Functional speech characteristics = Non-Fluent"

Review of Residents #155's care plan lacked any documented evidence that the facility staff developed a comprehensive person-centered care plan that addressed the resident's communication deficit.

During a face-to-face interview conducted on 04/14/22 at approximately 1:00 PM, Employee #2 (Director of Nursing) stated, "He has slurred speech and he gets frustrated quickly." Employee

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#2 reviewed the care plan and acknowledged the findings.

B. Review of the document titled "Situation, Background, Assessment and Request (SBAR) ... communication tool" dated 03/30/22 at 6:40 PM, "Resident is alert and verbally responsive Resident complaint of chest pain radiating to the abdomen. NP (Nurse Practitioner) ... ordered to be transferred to the hospital for further evaluation. Writer called 911 at 3:15 PM, arrived at 3:23 PM and left with resident at 4:04 PM to [Hospital name]."

Review of a Discharge Summary dated 03/31/22 showed, "Resident was admitted on 03/30/22 and discharged on 3/31/22. He [Resident #155] is being discharged hemodynamically stable to follow up with a cardiologist as outpatient. He will also need an echo outpatient."

Resident #155's care plan lacked documented evidence that the facility's staff developed a comprehensive person-centered care plan that addressed the resident's complaint of chest pains and the follow up care required.

During a face-to-face interview conducted on 04/18/22 at 11:43 AM, with Employee #2 (Director of Nursing) stated, "The care plan was not updated, we will have to educate everyone."

7. Facility staff failed to develop a comprehensive care plan to address Resident #180's behavior of frequently urinating on the bathroom floor, smearing the bathroom with feces.

Resident #180 was admitted to the facility on 11/16/17 with the following diagnoses:

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Unspecified Dementia Without Behavioral Disturbance, Parkinson's Disease and Anxiety Disorder.

According to the Quarterly Minimum Data Set dated 03/03/22, the resident was coded "15" under Section C (Cognitive Patterns), a BIMS Score, indicating that he was cognitively intact.

Under Section E0200 (Behavior), the resident was coded as "0" indicating that no behavior symptoms were exhibited.

Under Section G0110 Functional Status, the resident was coded as "1", indicating he required supervision for toilet use, with one-person physical assist.

Under Section H (Bladder and Bowel) the resident was coded as such:

H0200 (Urinary Toileting Program) = No

H0300 (Urinary Incontinence) = 2, indicating he was frequently incontinent

H0400 (Bowel Continence) = 2, indicating he was frequently incontinent

H0500 (Bowel Toileting Program) = No

During an environmental tour of the facility on 03/30/22 at approximately 4:00 PM, a urine odor was noted in the bathroom that services the resident in room #515 and #516 on unit 5 North. Resident #64, in room #516, complained that Resident #180 in room #515, frequently urinates on the bathroom floor, and smears the bathroom with feces. This, he said, has been going on since

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the resident moved in sometime last year. Resident #64 also stated that staff are aware and have even seen Resident #180 urinate on the bathroom floor.

Face-to-face interviews were conducted on 04/07/22, between 1:15 PM and 2:00 PM with the following employees:

Employee #51 (Registered Nurse) confirmed that Resident #180 often urinates on the floor, in his room and in the bathroom.

Employee #52 (CNA) said that Resident #180 sometimes urinates on the floor in his room and in the bathroom, and his hands must be cleaned every time he goes to the bathroom because he gets feces on his hand. Staff are aware of Resident #180's behavior and it is documented.

Employee #50 (CNA) said that Resident #180 urinates on the floor, gets feces on his hands and messes up the bathroom.

Employee #53 (CNA) has worked on 5 North for 5 years. She stated that Resident #180 urinates on the floor and gets feces on his fingers when he tries to wipe himself. Nursing staff is aware, and it is documented.

During a review of Resident #180's clinical records on 04/11/2022 at 10:25 AM with Employee #4 (Educator), she confirmed the finding and was not able to provide documented evidence that facility staff developed a comprehensive care plan with goals and interventions to address Resident #180's behavior of frequently urinating on the bathroom floor, smearing the bathroom with feces.

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8. Facility staff failed to implement Resident #403's refusal care plan.

Review of the FRI (Facility Reported Incident) dated 03/21/22, documented " ...At 10:45 AM resident was observed in her room bathroom sitting the commode and was unresponsive. Large amount of BM (Bowel Movement) was observed on floor. On assessment, resident has no vital signs. She was transferred to her bed and CPR initiated."

Resident #403 was re-admitted to the facility on 02/10/22, with multiple diagnoses including Respiratory Failure with Hypercapnia, Chronic Obstructive Pulmonary Disease, Unspecified, Tracheostomy Status and Right Heart Failure Due to Left Heart Failure.

Review of the Admission Minimum Data Set (MDS) dated 02/16/22, revealed that facility staff coded the following:

In Section C (Cognitive Patterns): a Brief Interview for Mental Status (BIMS) Summary score "08", indicating moderately impaired cognition

In Section E (Behavior) E0100 Potential indicators of psychosis "None of the above" E08000 Rejection of Care -Presence & Frequency "0- Behavior not exhibited"

In Section G (Functional Status): Bed mobility "Limited assistance" requiring "Two-person physical assist"; "Transfer "Extensive assistance" requiring "Two-person physical assist"; "Walk in room "Limited assistance" requiring "One-person

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physical assist"; "Toilet use "Extensive assistance" requiring "One-person physical assist"; "Personal hygiene "Limited assistance" requiring "One-person physical assist"

In Section O (Special Treatments, Procedures, and Programs) O0100 Respiratory Treatments "Oxygen Therapy, Suctioning and Tracheostomy care" was coded by facility staff.

Review of the physician's orders revealed the following:

02/11/22 "NPO (Nothing by mouth) diet NPO texture NPO for Bolus via PEG (percutaneous endoscopic gastrostomy) tube"

Review of the care plan with a focus area of "[Resident #403] is resistive/noncompliant with treatment/care (Refusing ADL's, Shower, Trach mask, g-tube feeding ...) related to disease ...Resident is NPO (Nothing by mouth) Daughter is feeding resident regular food despite education" revised date 02/16/22 ... "If resists care, leave and return later, provide education to patient and family, Psych (Psychiatry) consult as ordered ..."

Review of the nursing progress notes revealed the following:

03/09/22 at 11:24 PM "Resident refused all medications ..."

03/10/22 at 11:15 AM "Change Inner Cannula Every Shift every 4 hours Refused"

03/11/22 at 11:12 AM "Suction Trach Every 4 Hours and as Needed every 4 hours Refused"

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F 656	Continued From page 143 03/18/22 at 9:15 AM "...sitting on the bed refused oxygen via trach (Tracheostomy) mask no sign of resp (respiratory) distress noted ...Resident refused trach care, suction and neb (nebulizer) Tx (treatment) ..." There was no documented evidence in the medical record showing that facility staff followed the refusal of care plan to leave and return later when care is refused and provide education to the resident and family. During a face-to-face interview conducted on 04/13/22 at 11:20 AM, Employee #9 (Registered Nurse) acknowledged the finding and stated, "When she (Resident #403) first came, we did trach care and then she started refusing ...Sometimes I would teach."	F 656		8/24/22
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		

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F 657	Continued From page 144 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for eight (8) of 105 sampled residents, the facility staff failed to revise the comprehensive care plans to address: (1) a resident's dental needs; (2) two residents with physically aggressive behaviors. Residents' #27, #82 and #151. The findings include: Review the facility policy entitled, "Interdisciplinary Team Meeting (Care Plan Meeting)" revised 03/2022 documented, "... A comprehensive, individualized care plan will ... be reviewed and revised by the interdisciplinary team..." Review the facility policy entitled, "Resident-To-Resident Altercation/Incidents" revised 01/2022 documented, " ... When a resident is observed or identified as being aggressive to having aggressive behavior or has the potential for abusing other residents, an assessment of strategies to prevent such incidents from occurring will be provided by the Interdisciplinary Team (IDT) ... These immediate actions may include ... monitor and adjust care to reduce negative outcomes ... aggressor placed	F 657	F657 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #27 was assessed from head to toe on 4/26/2022, resident did not suffer any negative outcome. MD/RP notified on 4/26/22 Care plan will be revised to address dental needs immediately but no later than 8/24/22. Resident #82 was assessed from head to toe on 4/26/2022, resident did not suffer any negative outcome. MD/RP notified on 4/26/22. Care plan will be updated to address physical aggressive behavior immediately but no later than 8/24/2022.Resident was taken by DC police on 7/20/22, no longer in the facility. Resident #95 was assessed from head to toe on 4/26/22, resident suffered no negative outcome.MD/RP notified on 4/26/22 Care plan will be updated immediately but no later than 8/24/22. Resident # 151 was assessed on 4/26/2022, resident did not suffer any negative outcome. MD/RP updated on 4/26/2022. Care plan updated to address aggressive behavior will be revised immediately but no later than 8/24/2022. Resident #126 was assessed from head to toe on 4/26/2022. Resident suffered no negative outcome. MD/RP notified on 4/26/22. Care plan will be revised to indicate resident is two persons physical assist with transfer immediately but no later than 8/24/22.	8/24/22

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F 657	Continued From page 145 on 1:1 monitoring ... the care plan will be updated with the interventions in place to prevent and deescalate behaviors by the licensed nurses/manager..." 1. Facility staff failed to revise the care plans to address Resident #27's dental needs. Resident #27 was admitted to the facility on 05/06/20 with the following diagnoses: Diabetes and End-stage Renal Failure. Review of a progress note dated 03/16/22 showed, "Resident was seen by [Dentist name] during the shift and had tooth extraction ...Has been advised not to suck on candies or through a straw, not to drink hot or carbonated drinks to avoid spicy foods ..." Review of Resident #27's comprehensive care plan showed a focus area, "[Resident Name] has potential for Dental or oral cavity health problem related carious teeth, poor oral hygiene" initiated on 05/06/20 ... Assist with oral hygiene as needed. Observe for report any changes in the oral cavity, chewing ability, signs, and symptoms of oral pain ... treatment as ordered. Refer to the dentist for evaluation and recommendation ..." The evidence showed that facility staff failed to revise Resident #27's care plan to include the resident's tooth extraction (on 03/16/22) and aftercare. During a face-to-face interview conducted on 04/16/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), he acknowledged the findings.	F 657	Resident # 182 was assessed from head to toe on 4/26/2022, resident suffered no negative outcomes.MD/RP notified on 4/26/22. Care plan will be updated to include dialysis perma cath site on the right chest immediately, but not later than 8/24/22 Resident #404 expired in the hospital 2/21/22	8/24/22

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F 657	Continued From page 146 2. Facility failed to revise the comprehensive care plans to address Resident #82's and #151's physically aggressive behaviors (resident-to-resident altercations). 2A. Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, "...The charge nurse observed [Resident 404] sitting on the floor besides his roommate's ... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..." Resident #82 was admitted to the facility on 09/15/21with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss. Review of Resident #82's medical record revealed: A Quarterly MDS dated 01/31/22 that showed facility staff coded, a BIMS summary score, "14", indicating intact cognitive response. In section E (behavior), the resident was coded for not exhibiting physical or behavior symptoms towards others. 02/18/22 (Created date) [Care Plan focus area] "[Resident #82] is verbal[ly] abusive to staff using profanities related to: cognitive impairment... Provide privacy/remove to private area. Provide supervision in social gatherings/recreation ...	F 657	F657 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility with aggressive behavior, dialysis residents, residents with two persons physical assist with transfer have the potential to be affected by this practice. House wide audit will be conducted by the ADON, Clinical care coordinator, Unit Managers and Supervisors to ensure that care plans are revised, that the comprehensive care plans are person centered, that all diagnosis are care planed and that care plan interventions are implemented as indicated. Any issues found will be corrected by 8/24/22 The interdisciplinary team members such as the dietitian, clinical team ,social services team, will ensure that all residents have a comprehensive care plan in place that reflect their diagnosis and that the interventions are implemented as indicated. Any issues found will be addressed by 8/24/22. MEASURES TO PREVENT RECURRENCE Unit Managers /supervisors will ensure that there is a care plan in place for residents with dental needs monthly. Supervisors will be notified at validation meeting or through shift to shift report sheet. Any issues found will be addressed by 8/24/22.	8/24/22

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F 657	Continued From page 147 Psych consult ... Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior." 02/22/22 at 2:20 PM [Nurses Note] "[Resident #82] ... told the charge nurse "I hit him (Resident #404) because he came to my bed to bother me... that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him [Resident #404] on the chin and he fell..." Review of the comprehensive care plan on 04/05/22 lacked documented evidence that facility staff revised Resident #82's behavior care plan to include his physically aggressive behavior towards another resident (Resident #404) after a resident-to-resident altercation (on 02/21/22). During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 acknowledged the finding and made no further comment. 2B. Review of the FRI dated 12/09/21 documented, "... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..." Resident #151 was re-admitted to the facility on 12/02/21 with multiple diagnoses that included: Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia. Review of Resident #151's medical record revealed: 12/08/2021 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe	F 657	In-service will be provided by staff educator/ designee to all licensed nursing staff on the need to ensure that all residents' comprehensive care plans are revised and implemented as indicated by 8/24/2022. Repeat in-service will be conducted as needed. House wide audit will be carried out by ADON/Clinical care coordinator, unit managers and supervisors to ensure that all the residents have comprehensive care plan in place and that the care plans are revised and implemented as indicated. Any issues found will be corrected by 8/24//22 Unit managers /supervisors will conduct audit to ensure that a care plan is in place to address dental needs for residents wearing dentures. Names of residents with dental problems will be provided to the supervisors through the shift to shift report. Weekly .Any issues found will be corrected by 8/24/22. Unit managers/ supervisors will audit residents' chart monthly to ensure that care plans are revised to indicate residents' aggressive behavior. Any issues found will be addressed by 8/24/22 Supervisors / Unit managers will ensure that care plans are updated to reflect access site for dialysis residents weekly Any issues found will be addressed by 8/24/22. Charge nurses will ensure weekly that care plans are revised to indicate two persons physical assist for applicable residents and the C N A ;s are implementing care per the care plan Any issues found will be addressed by 8/24/22.	8/25/22

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F 657	Continued From page 148 cognitive impairment. In Section E (Behavior): E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes" E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - "Behavior of this type occurred 1 to 3 days", verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - "Behavior of this type occurred 4 to 6 days", Impact on Resident ... Put the resident at significant risk for physical illness or injury? "yes"; impact on others ... put others at significant risk of physical injury? "yes"; significantly intrude on the privacy or activity of others? "yes"; significantly disrupt care or living environment? "yes" 12/08/21 at 11:18 AM [Nurses Note] "... At 0730AM, the [Security Officer's Name] and the [Receptionist's Name] observed resident [#151] assaulting another resident [Resident #71] at the front of the building. The security officer and the receptionist ran to the residents and separated both residents... [Resident #71] was interviewed. He said, 'the man jumped on me in front of the building for no reason. I have never spoken to him. I don't know where this came from ... [Resident #71] was assessed and small scratch mark observed on the back of his left hand..." Review of the Care Plan revealed: 07/27/21 (Revision date) Focus area, "[Resident	F 657	MONITORING CORRECTIVE ACTIONS: DON/Designee will conduct house wide audit to validate that all residents have person-centered comprehensive care plan in place, that are being revised and implemented as indicated. This audit will take place weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI Committee.	8/24/22

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#151] at risk for changes in behavior problems related to: agitation ..."

10/18/21 (Revision date) Focus area, "[Resident #151] has problematic manner in which resident acts characterized by inappropriate behavior ... kicking and hitting ..."

10/20/21 (Revision date) Focus area, "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..."

10/22/21 (Revision date) Focus area, "Resident #151] has behavior problem... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor... 1:1 staff monitoring for safety until seen by psych or sitter is available..."

Further of Resident #151's comprehensive care plans lacked documented evidence that facility staff revised the care plans to include interventions to address the resident's physically aggressive behavior towards another resident (Resident #71) after a resident-to-resident altercation (on 12/08/21).

During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 acknowledged the finding and stated, "[Resident #151] was put on 1:1 in January of 2022 and has not had any further incidences of resident-to-resident altercations.

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Based on record review and staff interview, for 11 of 105 sampled residents, the facility staff failed to update the comprehensive care plan with goals and approaches that address one (1) resident's visit to the dentist for actual tooth extractions, one (1) resident with a right upper arm fistula access site post-dialysis care, three (3) residents with a PermaCath; and three (3) resident exhibiting behaviors and failed to update one (1) residents care plan to address their need to have two (2) person physical assist. Residents' #27, #61, #82, #95, #126, #151,#71, #67, #182, #404 and #502.

The findings include:

Review the facility policy entitled, "Interdisciplinary Team Meeting (Care Plan Meeting)" revised 03/2022 documented, "... A comprehensive, individualized care plan will ... be reviewed and revised by the interdisciplinary team..."

Review the facility policy entitled, "Resident-To-Resident Altercation/Incidents" revised 01/2022 documented, " ... When a

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resident is observed or identified as being aggressive to having aggressive behavior or has the potential for abusing other residents, an assessment of strategies to prevent such incidents from occurring will be provided by the Interdisciplinary Team (IDT) ... These immediate actions may include ... monitor and adjust care to reduce negative outcomes ... aggressor placed on 1:1 monitoring ... the care plan will be updated with the interventions in place to prevent and deescalate behaviors by the licensed nurses/manager..."

1. Facility staff failed to revise Resident #27's care plan to include visit to the dentist and plans for the care for actual teeth extraction.

Resident #27 was admitted to the facility on 05/06/20 with the following diagnoses: Sickle cell Trait, Anemia, Heart failure, Hypertension, Diabetes, End-stage Renal failure dependence on renal dialysis, and major depressive disorder.

Reviewed Progress note dated 03/16/22 that showed "Resident was seen by the dentist [dentist name] during the shift and had tooth extraction ...Has been advised not to suck on candies or through a straw, not to drink hot or carbonated drinks to avoid spicy foods. Secondly, order to hold Apixaban medication [To prevent blood clotting] on Friday (03/18/22)

A review of Resident #27's comprehensive care plan showed a focus area, "[Resident Name] has potential for Dental or oral cavity health problem related carious teeth, poor oral hygiene initiated 05/06/20, with goals and intervention. Goal: Maintain oral hygiene as evidenced by moist mucus membranes fresh smelling breath.

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Interventions: Assist with oral hygiene as needed. Observe for report any changes in the oral cavity, chewing ability, signs, and symptoms of oral pain, OT evaluation, and treatment as ordered. Refer to the dentist for evaluation and recommendation per PHY.[physician] orders."

During a face-to-face interview conducted on 04/16/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), He acknowledged the findings.

2. Facility staff ailed to revise the care plan to include Resident #61 with a right upper arm fistula access site post-dialysis care.

Resident #61 was admitted to the facility on 11/06/20 with multiple diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Viral Hepatitis C, Anemia, Hypertension, Peripheral Vascular Disease, Acute Kidney failure, Systemic Inflammatory response syndrome, and Anxiety.

Reviewed of hospital discharged information (Preliminary report) dated 03/23/22 showed "(resident) When asked why he did not want dialysis he said the needle prick hurt him. (resident) showed me the location of his fistula on the right upper arm."

A review of Resident #61's comprehensive care plan showed a focus area, "[Resident Name] needs dialysis hemo/t renal failure on Tuesday, Thursday, and Saturdays. ..." was initiated on 11/09/20 with goals and interventions. Goal: will have no s/sx [signs and symptoms] of complications from dialysis ..., Interventions: Check and change dressing daily at access site.,

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Do not draw blood or take B/P [blood pressure] in the right arm with graft. Encouraged resident to go for the scheduled dialysis appointment.

Reviewed of the Physician order dated as followed:

03/28/22 showed "Dialysis emergency kit at bedside at all times, check every shift for ESRD (End-stage renal disease)."

03/31/22 showed "Dialysis: Tuesday, Thursday, Saturdays, every day shift every Tue [Tuesday], Thur [Thursday], Sat. [Saturday]"

Continued review revealed that facility staff failed to review and revise this focus area with goals and interventions to address Resident #61's post dialysis treatment to include the emergency kit at the bedside, to remove access site dressing 2- 4 hours post dialysis, to assess daily for bruit and Thrill, to assess for pain, to monitor fluid intake due to resident fluid restriction, and the dialysis center contact information.

During a face-to-face interview conducted on 04/16/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), He acknowledged the findings.

3. Facility staff failed to revise the behavior care plan Resident #82 to include physically aggressive behavior towards other resident (Resident #404) after he was involved in a resident-to-resident altercation.

Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, " ...The charge nurse observed [Resident 404] sitting on the floor

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besides his roommate's ... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..."

Review of a Complaint dated 03/26/22 documented, " ...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's Name] told [news outlet] in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..."

Review of a Complaint dated 03/31/22 documented, " ...Avoidable death. Comments: Patient assaulted in nursing home. Beneficiary was assaulted 02/22/22 in skilled nursing facility by another resident. He sustained blunt head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died ..."

Resident #82 was admitted to the facility on 09/15/21with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss.

Review of Resident #82's medical record revealed:

A Quarterly MDS dated 01/31/22 that showed facility staff coded the following:

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a BIMS summary score, "14", indicating intact cognitive response and no physical or behavior symptoms directed towards others.

02/18/22 (Created date) [Care Plan] "[Resident #82] is verbal abusive to staff using profanities related to: cognitive impairment... Provide privacy/remove to private area. Provide supervision in social gatherings/recreation ... Psych consult ... Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior."

02/22/22 at 2:20 PM [Nurses Note] "Resident #82] ... told the charge nurse "I hit him (Resident #404) because he came to my bed to bother me ... that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ...."

Review of the comprehensive care plan on 04/05/22 lacked documented evidence to show facility staff revised Resident #82's behavior care plan to include physically aggressive behavior towards another resident (Resident #404).

During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 acknowledged the finding and made no comment.

4. Failed to update care plan to include Resident #95 with a PermaCath on the right chest area access site post-dialysis care.

Resident #95 was admitted to the facility on 02/11/22 with multiple diagnoses including End-stage Renal Disease, Anemia, Hypertension,

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Hyperlipidemia, Gastroesophageal Reflux Disease, Major Depressive Disorder, and Anxiety.

A review of Resident #95's comprehensive care plan showed a focus area, "[Resident Name] needs hemodialysis on Monday, Wednesday, and Friday's r/t ESRD. ..." was initiated on 02/14/22 with goals and interventions. Goal: will have no s/sx [signs and symptoms] of complications from dialysis ..., Interventions: Encouraged resident to go for the scheduled dialysis appointment. (Resident receives dialysis (3 times a week)."

Reviewed of the physician's orders dated as followed:

02/11/22 showed "Assess dialysis PermaCath site on Right chest for bleeding, redness, tenderness, and swelling every shift. (no B/P [blood pressure] and no blood draw on this arm every shift. Dialysis emergency kit at the bedside at all times, check every shift."

02/14/22 showed "Dialysis: Monday, Wednesday, Fridays, every day shift every ..., Check dialysis right chest PermaCath site upon return from dialysis center for bleeding, redness, swelling and tenderness. Every evening shifts every mon. [Monday], wed. [Wednesday], fri. [Friday],"

Continued review revealed that facility staff failed to revise this focus area with goals and interventions to address Resident #95's post-dialysis care to include checking the resident's right chest PermaCath site upon return from dialysis center for bleeding, redness, swelling, and tenderness. Keep PermaCath dressing dry, no dressing change (done only in dialysis), Dialysis emergency kit at the bedside at

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all times, and is checked every shift. Dialysis center contact information.

During a face-to-face interview conducted on 04/16/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), He acknowledged the findings.

5. Facility staff failed to revise Resident #126's care plan after completion of the Minimum Data Set (MDS) assessment which required resident to have two (2) person physical assist when transferring between areas.

Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Heart Failure Unspecified, Presence of Right Artificial Knee Joint, Chronic Kidney Disease, Stage 4 (Severe), Pressure Ulcer Sacral Region Unstageable, and Other Lack of Coordination.

Review of the Admission Minimum Data Set (MDS) dated 11/17/21, revealed that the facility staff coded the following:

In Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "11" Indicating moderately impaired cognition.

In Section G (Functional Status): Transfer "Extensive assistance" requiring "Two-person physical assist"

Review of the nursing progress note dated 12/23/21 at 11:50 AM documented, "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the ¼ side rail ..."

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Resident #126's care plan revealed that it failed to address the residents need for a two-person physical assist when being transferred.

During a face-to-face interview conducted on 04/20/22 at 10:45 AM with Employee #58 (Certified Nurse Aide) stated "It was just me who transferred her [Resident #126] to the bed. Nobody was there only me." Employee # 58 was responding to questions about the incident with Resident #126 that occurred n 12/23/2021 in which staff was transferring resident from the wheelchair to the bed.

During a face-to-face interview conducted on 04/20/22 at 1:38 PM with Employee #7 acknowledged the finding and stated, "Usually when I put a two person assist its for a Hoyer (mechanaical lift)."

6. Facility staff failed to revise the care plan interventions for Resident #151 who was involved in two (2) resident-to-resident altercations (Resident's #71 and #67).

Review of the FRI dated 12/09/21 documented, " ... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Review of the FRI dated 01/02/22 documented, " ...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby ..."

Resident Background Information

A. Resident #151 was admitted to the facility on 10/22/20 with multiple diagnoses that included:

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Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia.

Review of Resident #151's medical record revealed:

12/08/2021 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe cognitive impairment.

In Section E (Behavior):

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - "Behavior of this type occurred 1 to 3 days", verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - "Behavior of this type occurred 4 to 6 days", Impact on Resident ... Put the resident at significant risk for physical illness or injury? "yes"; impact on others ... put others at significant risk of physical injury? "yes"; significantly intrude on the privacy or activity of others? "yes"; significantly disrupt care or living environment? "yes"

In Section G (Functional Status): Activities of Daily Living (ADL) Assistance - bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, Resident #151 required "supervision" and "one person physical assist"

Review of the Care Plan revealed:

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F 657	Continued From page 160 07/27/21 (Revision date) "As evidenced by a positive PASARR (Preadmission Screening and Resident Review) Level I screen and Level II evaluation, it was determined that the resident needs Specialized Services while in the Nursing Facility. Related to: schizophrenia ...Inform the MD (medical doctor) if the Individual has a serious health decline and services previously agreed to may need to be modified or deleted. Inform the MD of any significant changes may require additional evaluation to add, modify or remove services ..." 07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..." 10/18/21 (Revision date) "[Resident #151] has problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with taking medications, non compliant with vital signs, non compliant with shaving and showers. Non compliant with Wader guard placement kicking and hitting ..." 10/20/21 (Revision date) "[Resident #151] has impaired cognitive function or impaired thought processes r/t (related to) Dementia..." 10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..."	F 657		8/24/22

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10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..."

B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension.
Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21where facility staff coded a BIMS summary score of "09", indicating moderate cognitive impairment, no potential indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions.

C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance.

Review of Resident #67's medical revealed, a Quarterly MDS dated 11/06/21 where facility staff coded a BIMS summary score of "14", indicating intact cognitive response, no potential indicators of psychosis, no physical or verbal behavioral symptoms, limited to extensive assistance with one person physical assist for ADLs and no limitations in range of motion.

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Altercation #1 involving Residents #151 and #71:

12/08/21 at 11:18 AM [Nurses Note] " ... At 0730AM, the [Security Officer's Name] and the [Receptionist's Name] observed resident [#151] assaulting another resident [Resident #71] at the front of the building. The security officer and the receptionist ran to the residents and separated both residents... [Resident #71] was interviewed. He said, 'the man jumped on me in front of the building for no reason. I have never spoken to him. I don't know where this came from today' ... asked [Resident #151] why he assaulted [Resident #71]. He said, 'he raped my daughter' ... The MPD (Metropolitan Police Department) was called ... took [Resident #151] because of his aggressive behavior and transported him to [Hospital Name] at 0809 (AM) for evaluation. [Resident #71] was assessed and small scratch mark observed on the back of his left hand..."

Altercation #2 involving Residents #151 and #67:

12/30/21 at 11:30 AM [Nurses Note] " ... At 2030 (8:30 PM) on 12/29/2 (12/29/21).., Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby; the receptionist notified the supervisor; the supervisor assessed [Resident #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45 PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one

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of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site. No swelling, discoloration or open area observed during assessment. He denied pain ..."

The evidence showed that despite documented aggressive behaviors toward Resident #71 on 10/08/2021, facility staff failed to revise Resident #151's care plan with interventions to protect other residents. Subsequently, Resident #151 attacked another resident (Resident #67) on 12/29/2021.

During a face-to-face interview conducted on 04/05/2022 at 2:59 PM, Employee #7 acknowledged the finding and stated, "[Resident #151] was put on 1:1 and has had no further incidences of resident-to-resident altercations.

7. Facility staff failed to update the care plan to include Resident #182's PermaCath site on the right chest access site post-dialysis care.

Resident #182 was admitted to the facility on 11/30/2021 with multiple diagnoses including Diabetes Mellitus, Hyperlipidemia, Chronic Viral Hepatitis C, Anemia, Hypertension, and Heart Failure.

A review of Resident #182's comprehensive care plan showed a focus area, "[Resident Name] needs dialysis hemo/t renal failure on Tuesday, Thursday, and Saturdays. ..." was initiated on 11/09/2020 with goals and interventions. Goal: will have no s/sx [signs and symptoms] of complications from dialysis ..., Interventions: Check and change dressing daily at access site.,

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Do not draw blood or take B/P [blood pressure] in the right arm with graft. Encouraged resident to go for the scheduled dialysis appointment.

Review of the physician's order dated 2/22/22 showed "Dialysis: Tuesday, Thursday, Saturdays, every day shift every ..., Check dialysis right chest PermaCath site upon return from dialysis center for bleeding, redness, swelling and tenderness. Every evening shift every Tuesday, Thursday, and Saturday, Dialysis emergency kit at the bedside at all times, check every shift. Assess dialysis PermaCath site on right chest permaCath for bleeding, redness, tenderness and swelling every shift. (no B/P and no blood draw on this arm) every shift."

There was no evidence that facility staff revised this focus area with goals and interventions to address Resident #182's post dialysis care to include assessing/checking the resident's right chest PermaCath site upon return from dialysis center for bleeding, redness, swelling and tenderness. Keep PermaCath dressing dry, dressing change done in dialysis, Dialysis emergency kit at bedside at all times, check every shift. Dialysis center contact information.

During a face-to-face interview conducted on 04/14/2022, at approximately 1:15 PM with Employee # 8 (Nurse Manager), He acknowledged the findings.

8. Facility staff failed to review Resident #404's care plan interventions for effectiveness and failed to revise and implement new interventions to address behavior of sleeping in other resident's beds resulting in serious injury.

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Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, " ...The charge nurse observed [Resident 404] sitting on the floor besides his roommate's ... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..."

Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's Name] ... in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..."

Review of a Complaint dated 03/31/2022 documented, "...Avoidable death. Comments: Patient assaulted in nursing home. Beneficiary was assaulted 02/22/2022 in skilled nursing facility by another resident. He sustained blunt head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died ..."

Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack.

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Review of Resident #404's medical record revealed the following:

12/16/21 [Quarterly MDS] showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment.

In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily"

In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion

In Section P (Restraints and Alarms), wander/elopement alarm, "Used daily"

Care Plan: 07/27/21 (Revision date) ["Resident #404 is at risk for Elopement: cognitive impairment, dementia ... Observed wondering at the adjacent unit on 5/28/2021. Wandering to the adjacent unit on 7/3/21. Redirected easily. Wandering to the adjacent unit on 6/8/2021. Easily redirected. Wondering on 7/11/2021. Redirected. Wondering to the adjacent unit 7/27/2021, Easily redirected ... Avoid leaving unattended or unobserved for long periods of time. Hourly elopement/wandering monitoring and location."

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F 657	Continued From page 167 Review of the Daily Behavior Documentation showed the following: 02/02/22 at 2:12 PM "... Elopement attempts. Wandering ....sleeping in other people's bed... Behaviors are constant." 02/03/22 at 1:12 PM "... sleeping in other people bed. Behaviors are constant." 02/07/22 at 1:52 PM "... sleeping in other people's bed. Behaviors are constant." 02/09/22 at 1:47 PM "...sleeping in other peoples bed. Behaviors are constant." 02/10/22 at 12:17 PM "...sleeping in other peoples bed...Behaviors are constant." 02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant." 02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant." 02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant." 02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant." 02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant." 02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant."	F 657		8/24/22

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Skin Observation Tool:

02/21/22 at 2:40 AM "Observations... face... Blood was coming from his mouth, we managed to stop it by applying cold compress and ice..."

Situation Background Assessment Request (SBAR): 02/21/22 at 4:00 AM "Situation... The resident got hit by his roommate... Background: Altered mental status... Resident Reports Pain? 'No'. Non-verbal indicators of pain evident? 'No'. Functional Status unchanged... Skin/Wound Status- (area was left blank) ... Assessment ... (area was left blank) ... Additional comments ... At approximately 02:30 am ... The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face. The writer immediately notify the supervisor and called 911. DC (District of Columbia) police. I saw [Resident #82] also sitting on his walker facing [Resident #404]. The writer asked [Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware."

02/21/22 at 4:16 AM [Nursing Supervisor Progress Note] "The Charge Nurse reported that While making routine rounds, Resident [#404] was observed sitting on the floor beside Room 420 A. Resident was noted with some blood on the left side of his face, a quick assessment was made, he was assessed for pain and discomfort. Resident could not describe what happened. This is his base line. A quick assessment was done,

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Range of motion exercise was done, ice was applied to the left side of the face, vital signs was monitored T. (temperature) 96.5, P. (pulse) 82, R. (respirations) 18, B.P. (blood pressure) 140/90, Spoe (sp) (oxygen saturation) 97% on Room Air."

02/21/22 at 1:43 PM [Nurses Note] "A call was placed to [Hospital Name] to know about the status of the resident [#404] in the ER, spoke with nurse [Registered Nurse's Name] who stated resident (#404) is critically ill, he has been intubated and about to be transferred to ICU (intensive care unit). RP ... made aware."

During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, " ... Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D [Resident #404] Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed ..."

This evidence showed:

a. Although the facility had a care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revise to address the residents intrusive behavior (wandering into resident rooms and sleeping in their beds).

b. Facility staff failed to document the names, room numbers of residents who were affected by Resident #404's behavior; and failed to assess how Resident #404's behavior caused other residents to feel (i.e. upset that someone is in their room, sleeping in their bed).

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c. Although the staff record that the resident was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that monitoring the resident was increased.

During a face-to-face interview conducted on 04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) stated, "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make updates as needed." When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in other resident's beds, Employee #7 stated, "I was never made aware by the nurses on the unit. I knew him [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation ..." that stated Resident #404's behavior, Employee #7 stated, "I didn't see it."

9. Failed to update care plan to include Resident #502 with a PermaCath on the left chest area access site post-dialysis care.

Resident #502 was admitted to the facility on 03/17/22 with multiple diagnoses including End-stage Renal Disease, Anemia, Chronic Pancreatitis, Chronic Viral Hep-C, Hypertension, Peripheral Vascular Disease, Hyperlipidemia, and Cirrhosis of the liver.

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A review of Resident #502's comprehensive care plan showed a focus area, "[Resident Name] has renal insufficiency r/t Chronic kidney disease, Hep-c, Chronic pancreatic disease was initiated 03/22/22 with goals and interventions. Goal: will have no s/sx [signs and symptoms] of complications related to fluid deficit. Interventions: Monitor and report changes in mental status ... reviews/sx that should be reported to medical team such as difficulty breathing, increased fatigue, confusion edema, weight gain, ... The importance of compliance with treatment plan, fluid restrictions, dietary restrictions, and energy conservation, The importance of compliance with medications and dialysis treatment. ..."

Review of the physician's order dated 03/17/22 showed "Dialysis: Tuesday, Thursday, Saturdays, every day shift every ..., Check dialysis PermaCath site upon return from dialysis center for bleeding, redness, swelling and tenderness. every evening shift every Tuesday, Thursday, and Saturday, Dialysis emergency kit at the bedside at all times, check every shift. Assess dialysis PermaCath site on left chest permaCath for bleeding, redness, tenderness and swelling every shift every shift."

Continued review revealed that facility staff failed to revise this focus area care plan with goals and interventions to address Resident #502's post-dialysis care to include assessing/checking the resident's left chest PermaCath site upon return from dialysis center for bleeding, redness, swelling and tenderness. Keep PermaCath dressing dry, dressing change done in dialysis, Dialysis emergency kit at the bedside at all times, check every shift. Dialysis center contact information.

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F 657	Continued From page 172 During a face-to-face interview conducted on 04/14/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), he acknowledged the finding.	F 657		8/24/22
F 660 SS=E	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.	F 660	F 660 CORECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #155 was assessed from head to toe by Unit manager on 4/26/22, resident did not suffer any negative outcome. MD/RP notified on 4/26/22. Discharge planning in place and will be modified as appropriate by 8/24/22 Resident # 170 was assessed from head to toe on 4/26/22, resident suffered no negative outcome.MD notified on 4/26/22. Discharged planning in place and will be modified as appropriate. Resident #227 was discharged home 4/1/22 Resident # 237 was assessed from head to toe on 4/26/22, by Unit manager, resident suffered no negative outcome.MD/RP notified on 4/26/22. Discharge plan in place and will be modified as appropriate. Resident #406 was sent to the hospital 2/10/22 and did not return to the facility. Resident # 412 was discharged home on 5/26/21	

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F 660	Continued From page 173 (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the	F 660	F 660 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Resident who are due for discharge have the potential to be affected by this practice. House wide audit will be conducted by social services team members to determine that there are no delays in the discharge process. Will ensure that documentation about the discharge process in in the residents' record and ensure that discharge needs are in place. Any issues found will be corrected by 8/24/22.	8/24/22

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F 660	Continued From page 174 discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for six (6) of 105 sampled residents, facility staff failed to: (1) have a discharge plan for one resident; (2) record/document information related to the resident's discharge plan to the community in the clinical record;(3) ensure the residents discharge needs were adequately identified and the results developed into a discharge plan. Residents' #155, #170, #227, #237, #406 and #412. The findings include: 1. Facility staff failed to update Resident #155's discharge plan and avoid unnecessary delays in the discharge process. Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses including, Dysphagia, Oropharyngeal Phase, Unspecified Lack of Coordination, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Dominant Side. Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, showed that facility staff coded the following: In section C (Cognitive Patterns) BIMS (Brief Interview for Mental Status) Summary Score "05" indicating severe cognitive impairment. In section Q (Participation in Assessment and	F 660	MEASURES TO PREVENT RECURRENCE Licensed Social worker will ensure that discharge planning for resident #155 is updated to ensure that there are no delays in the discharge process. Findings will be corrected by 8/24/22 Licensed social worker will also ensure that resident #170 discharge plan is in place to avoid delays in the discharge process. Findings will be corrected by 8/24/22 Licensed social worker will ensure that the needs for resident #237 are adequately identified to prevent delays in the discharge process. Findings will be corrected by 8/25422 In service will be provided by Staff educator/ Designee to all licensed social services employees on the need to identify the needs of residents who are due for discharge and ensure they are met in a timely manner to avoid delays in the discharge process. Training will be provided to all licensed nurses by staff educator/ Designee on the importance of proper documentation on the date, time and place where discharge planning meeting took place. Discussing resident's behavior during the IDT (resident, responsible party, clinical team)meeting is very important and must be documented. Unit manager /supervisors will audit charts of residents due for discharge to ensure the licensed social worker has a discharge plan in place and that the plan id followed ad indicated. Findings will be addressed by 8/2422	8/24/22

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F 660	Continued From page 175 Goal Setting), yes Resident participated in the assessment and that no family or representative participated Q0400 (Discharge Plan): "Is active discharge planning already occurring for the resident to return to the community? - No" Q0500 (Return to Community) "Ask the resident ...Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community? - No" Review of the care plan meeting notes revealed the following: 01/13/22 at 1:59 PM " ...They (Residents family) talked about things they felt like the facility and the SW were not doing ...They are not happy with the care at [facility] and they wanted him (Resident) moved to another facility ..." Review of the social work progress notes revealed the following: 11/29/21 at 4:17 PM "[Resident Representative] informed the social worker that she is trying to get him into ... assisted living. She stated that she needed certain documents to get him into the facility ... The SW (Social Worker) has called and requested for the social security income statement. They were supposed to fax it but there were some problems. The SW (Social Worker) also requested they mailed it ... In addition, the SW will meet her at the DMV (Department of Motor Vehicles) for [Resident #155] to get his ID (identification) ..." 12/29/21 at 5:11 PM, " ... [name of staff in	F 660	F660 MONITORING CORRECTIVE ACTION: Licensed Social services Director will audit residents' chart to ensure that there are no delays in discharge planning, that there is adequate documentation about resident's discharge plans. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected, and report presented to QAPI	~~8/24/22~~

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ombudsman office] the Ombudsman called the SW (Social Worker) and the Supervisory SW [name] stated that [Resident's sister] felt as if the SW and the transition worker were holding up the process towards [Resident #155] going into [Assisted Living Facility]"

01/06/22 at 3:18 PM, "The SW called [Assisted Living SW] ... [and]... She asked him what could she do to assist with the process of getting [Resident #155] into... assisted living facility ..."

03/29/22 at 1:05 PM, "...supervisor with ADRC (Aging and Disability Resource Center) sent an email out to the family and SW stating as follows ...I was able to contact ... at [assisted living facility] regarding the assessment that was completed for [Resident #155]. [Assisted Living SW] is currently looking into and will be sending it to me. In the event he cannot access the assessment he is willing to have another nurse come out and re-do the assessment."

Further review of the medical record lacked documented evidence of a discharge plan for Resident #155.

During a face-to -face interview conducted on 04/14/2022 at 3:44 PM, Employee #13 (Social Worker) acknowledged the finding and stated, "We started talking about other placements. The man from [assisted living facility] is coming back out to do another assessment ... this is a systemic issue."

2. Facility staff failed to record/document information related to the resident's discharge plan to the community in the clinical record for Residents #170 and #227.

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2A. Resident #170 was admitted to the facility on 08/16/18, with diagnoses which included, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Cirrhosis of Liver, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Muscle Weakness, Dependence on Renal Dialysis, and Hemiparesis.

According to the Quarterly Minimum Data Set Dated 02/14/22, Under Section C0500 BIMS Score showed Resident #170 was coded as "15", indicating that she was cognitively intact. Under Section E Behavior, the resident was coded as no behaviors exhibited.

Under Section G (Functional Status), the resident was coded as requiring supervision with set up under bed mobility, locomotion on and off unit, transferring, dressing, toilet use, and personal hygiene.

Under Section G0400 Functional Limitation in range of motion, the resident was coded as having no impairment of upper and lower extremity.

Under G0600 Mobility Devices the resident was coded as not using mobility devices.

Under Section Q, the resident was coded as participating in the discharge plan, having "An active discharge plan is already occurring for the resident to return to the community"; and has been referred to the local contact agency.

Care Plan last updated on 04/07/21, Focus area, "Goal and Expectation for discharge is to go home" ...Interventions, "Assess future placement

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setting to determine if resident's needs can be met ...review progress toward discharge during discharge meetings."

Social Work Progress Note dated 03/11/22 at 7:02 AM, read, "The SW (social worker) sat with [Resident #170] and assisted her in filling out the application for [Name of Assisted Living-LS], provided to her [Name of Transition Worker] ...The SW left a message in the presence of [Resident #170] and will attempt to call her again today regarding the completion of the packet so that it can be submitted with the proper documentation ASAP (as soon as possible)."

During a face-to-face interview with Employee #13 (Social Worker) on 04/11/22 at 3:20 PM she stated, "...We transitioned from [Name of Organization] to [Name of Organization]. We kept checking back with [Name of Case Manager], we are now working with [Name of Organization] and [Name of Case Manager] to get her (Resident #170) into another Assisted Living ...We will try [Name of Assisted Living] again to see if they are taking dialysis patients again, because that was months ago. [Name of Organization] is based of mental health and they have no openings for placement at this time...I have the application for [Name of Assisted Living]. We are still in the process of submitting it and the resident has to have an interview."

Through interview with Employee #13 it was determined that the actions taken toward discharge planning for Resident #170 have not been documented in her active clinical record. Also, from 03/10/22 to present, there was no evidence of an outcome from Employee #13's follow up with the [Transition Worker] regarding

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the status of the application.

2B. Resident #227 was admitted to the facility on 03/08/22 with diagnoses which included, Cognitive Communication Deficit, Cerebral Infraction, Chronic Obstructive Pulmonary Disease, Emphysema, Hypertension, Multiple Fractures of Ribs, and Non-Pressure Chronic Ulcer of Right Lower Leg with Necrosis of Muscle.

According to the Admission Minimum Data Set dated 03/14/22, Under Section C0500 BIMS Score showed Resident #227 was coded as a "12", indicating that he was cognitively intact.

Under Section E (Behavior), the resident was coded as no behaviors exhibited.

Under Section G (Functional Status), the resident was coded as requiring Supervision with one-person physical assist under bed mobility and locomotion on and off unit; He required limited assistance with one-person physical assistance for transferring, dressing, toilet use, and personal hygiene.

Under Section G0400, Functional Limitation in range of motion, the resident was coded as having impairment on one side of upper and lower extremity.

Under G0600, Mobility Devices the resident was coded as using a walker.

Under Section Q, the resident was coded as, "Expects to be discharged to the community"; "An active discharge plan is already occurring for the resident to return to the community."

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Review of the focus care plan "Resident shows potential for discharge and resident, relative, or representative expresses wish for discharge home" ...Interventions: Arrange transportation family will transport [Resident #227]. Assess future placement setting to determine if resident's needs can be met at home."

Review of the Social Work Progress Note dated 04/01/22 at 12:42 PM showed, "[Resident #227 D/C (discharged) home. Upon discharge this writer contact APS (Adult Protective Services) to file an APS report. [Resident #227] seemed puzzled upon discharge however this writer provided the son with his care navigator number and information ...Son stated that he will contact his case manager and follow up with her ..."

During a face-to-face interview with Employee #12 on 04/07/22 at 4:45 PM he stated, "We were told that he had a caseworker in the community through his insurance ...He has an assessment from Liberty ... in the system. The resident didn't want to wait to be discharged. He was irritated to be here. He wanted to go home ...I did not want him to go AMA (against medical advice). I called the case worker and left several messages and provided the number to the family. I was worried about the resident because he was not calm. That's why I call APS adult protective services. He was adamant about leaving. The son and resident told me that he had an aid. The son came (to the facility) with someone who said she was going to care for him. I didn't feel comfortable about him leaving with her. The resident was adamant about leaving the facility."

During a face-to-face interview with Employee #43 on 04/07/22 at 5:11 PM she stated, "The

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resident was supposed to leave on Tuesday 04/05/22. His son didn't come on Tuesday. He [Resident #227] was angry and wanted to go home with someone else. The son came on Friday and got him. The son was off on Friday and picked him up. He kept going to the social workers door saying he wanted to go home. He had a lot of anxiety."

There was no evidence that Employee #12 updated Resident #227's clinical record with the status of the liberty assessment and outcome. Employee #12 failed to document the date and time that he left a message for the resident's community case worker to discuss the resident's transitioning back into the community safely. There was no documentation in the clinical record regarding the resident's anxiety and behavior related to being discharged from the facility to the community.

Employee #12 acknowledged the findings on 04/05/22 at 4:45 PM; and Employee # 43 acknowledged the findings on 04/05/2022 at 5:11 PM.

3. Facility staff failed to ensure that Resident #237's, #406's and #412's discharge needs were adequately identified and the results developed into a discharge plan.

3A. Resident #237 was admitted to the facility on 07/19/19, with multiple diagnoses including Gout unspecified, Unspecified Atrial Fibrillation and Essential Hypertension.

Review of the Quarterly Minimum Data Set (MDS) dated 03/17/22 showed that facility staff coded the following:

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In section Q (Participation in Assessment and Goal Setting) Resident participated in assessment "Yes"

Q0300 Residents overall expectation Section was not coded

Q0400 Discharge plan: Is active discharge planning already occurring for the resident to return to the community? "Yes"

Review of the care plan notes revealed the following:

12/7/2021 at 9:11 AM, "...[Resident #237] is interested in obtaining his own housing and returning to the community the social worker is working with him towards that goal. He ... doesn't have his needed documents and the SW will assist him in obtaining them ..."

Review of the social work progress notes revealed the following:

03/17/2022 at 9:21 AM, "The SW (Social Worker) will be going to pick up birth certificates for [Resident #237] and additional residents to begin the process of discharge"

Further review of the medical record lacked documented evidence of a discharge plan for Resident #237.

During a face-to-face interview conducted on 04/07/22 at 1:10 PM, with Employee #13 (Social Worker) acknowledged the finding and stated, "It's been difficult for him, he's not disabled, and his income isn't enough where he can get an

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apartment. The plan is for discharge."

3B. Resident #406 was admitted to the facility on 01/28/22 with multiple diagnoses including, End Stage Renal Disease, Alcohol Abuse Uncomplicated and Hemiplegia and Hemiparesis Following Cerebral Infarction.

Review of the Admission Minimum Data Set (MDS) dated 02/03/22 showed facility staff coded the following:

In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "15", indicating intact cognition

In section G (Functional Status): Bed Mobility "Supervision" requiring "Setup"

Transfer "Limited assistance" requiring "One-person physical assist"

Dressing "Limited assistance" requiring "One-person physical assist"

Toilet use "Extensive assistance" requiring "One-person physical assist"

Mobility Devices "Cane/Crutch" "Wheelchair"

In section Q (Participation in Assessment and Goal Setting): Q0100 Resident participated in assessment "Yes"

Q0300, resident's overall goal ... "Expects to remain in this facility"

Q0400 Is active discharge planning already occurring for the resident to return to the

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community? "No"

Q0600 Has a referral been made to the local contact agency? "No-referral not needed"

Review of the social work progress notes revealed the following:

02/04/22 at 4:35 PM "...Spoke with [Resident #406] in reference his discharge plan and he stated that he does not have housing now at this time. Prior to his hospitalization he lived in a shelter. Housing resources for males will be explored and the appropriate referrals and recommendations will be implemented. Identification is a issue that need to be resolved in order to apply for housing. The discharge goal for [Resident #406] is to return to the community at some point..."

Review of the nursing progress notes showed the following:

02/08/22 at 4:16 PM "... He was observed on in the lobby with some of his belongings. His nephew was on his way to visited him, and he met resident at the front entrance with some of his belonging and asking his nephew to take him home. A meeting was held with [Resident #406's Relative], SW, admission and the unit manager. Resident attests he did mot (SP) know that he needs to sign a paper to leave AMA (Against Medical Advice). We convivence (sp) [Resdient #406] to stay until Friday coming when he will have a proper discharged (sp). However, he went outside with his [Relative] and all of a sudden he snatched into his case worker car. Resident was removed from the car, and brought inside the facility by his [Relative]. He agreed to wait until

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Thursday or Friday to be discharge. Psych. consult, and elopement risk initiated for preventive measure. He refused wander guard..."

02/10/22 at 8:13 AM "[Resident #406] was transferred to [hospital name]..."

Review of the care plan initiated on 02/07/22, with a focus area of "Safe and appropriate discharge." Showed the following interventions "...on discharge to community, encourage...to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety fear, distress., The clinical team along with [Resident #406] and ... RP (resident representative) will establish a pre-discharge plan with specific needs being discussed and addressed prior to discharge."

Further review of Resident #406's medical record lacked documented evidence of any updates, modifications or plans for the resident to safely discharge from the facility.

During a face-to-face interview conducted on 04/11/22 at 4:00 PM with Employee #10 (Director of Social Work) acknowledged the finding and stated, "He was only here a short time he wanted to leave AMA, it was not safe for him" and provided no explanation why there was nothing documented in the discharge plan about Resident #406 wanting to leave the facility against medical advice.

3C. Resident #412 was admitted to the facility on 02/26/21 with multiple diagnoses including, Hemiplegia Unspecified Affecting Left Nondominant Side, Cervical Disc Disorder With Myelopathy Cervicothoracic Region, and Other

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Abnormalities of Gait and Mobility.

Review of the Admission Minimum Data Set (MDS) dated 03/07/21, showed that facility staff coded the following:

In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "15" indicating intact cognition.

In section Q (Participation in Assessment and Goal Setting): Q0100 Resident participated in assessment "Yes"

Q0300, resident's overall goal, "Expects to be discharged to the community"

Indicated the information source for Q0300A "Resident"

Q0400 Is active discharge planning already occurring for the resident to return to the community? "No"

Review of the social work progress notes revealed the following:

03/01/21 at 12:52 PM, "This is an initial care conference meeting with the IDT (Interdisciplinary team) and resident. ...plans are to discharge home"

04/28/21 at 8:46 AM, "The Social [Worker] met with [Resident #412's] POA (Power of Attorney) today to begin the discharge process. Family is interested in participating in [agency name] The referral for the Waiver Program was completed ... the Clinical Team will meet again to continue discharge plkanning (sp)"

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F 660	Continued From page 187 05/10/21 at 1:48 PM, "[Resident #412] will be assessed for services in the community by [Agency name], 5/14/21 at 11:00 AM. The assigned Nurse will telephone [Resident #412] in his room if there are any additional information or questions sthe (sp) Nurse will consult this Social Worker" 05/25/21 at 5:52 PM, "... [Resident #412] cou (sp) further benefit from our skilled service program however he has requested to be discharged. ... [Resident #412] and his Responsible party have put in place a plan of care for the family to follow until the HHA (Home Health Agency) have been identified and put in place...[Resident # 412] will be discharged from [Facility]. Review of the care plan initiated on 03/01/21 revealed a focus area of "...Expectation id for the resident to have a safe an appropriate discharge home." Goal "The resident will be able to communicate verbal needs and required services to meet needs prior to discharge." Interventions "Discharge planning meeting will be held with IDT, resident and family" Review of a physician's orders showed on 05/26/21 "Discharge resident home with skilled musing (sp) PT (physical therapy)/OT (occupational therapy)/HHA and scripts (prescriptions) on 5/26/21." Further review of Resident #412's medical record lacked documented evidence of any updates, modifications or plans for the resident to safely discharge from the facility.	F 660		8/24/22

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F 660	Continued From page 188 During a face-to-face interview conducted on 04/11/22 at 3:51 PM, Employee #10 (Director of Social services) acknowledged the finding and stated, "When he came there was no way he could safely discharge."	F 660		8/24/22
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and	F 676	F 676 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS Resident # 82 was assessed from head to toe by Unit manager on 4/26/22, resident suffered no negative outcome.MD/RP notified on 8/21/22 Appointment will be scheduled no later than 8/21/2022 for resident to see the audiologist. Resident taken by DC Police for custody on 7/20/22 Resident#81 was assessed from head to toe on 4/26/22, resident suffered no negative outcome.MD/RP notified resident will be assisted with wearing dentures during meals on 4/26/22	

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F 676	Continued From page 189 snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, for two (2) of 105 sampled residents, facility staff failed to: 1) assist a resident with applying her dentures before meals; and 2) failed to ensure one (1) resident was seen by audiology to address his ability to hear when communicating with others. Residents' #81 and #82. The findings include: 1. Facility staff failed to assist Resident #81 with applying her dentures before meals. During an observation on 03/30/22 at approximately 1:30 PM, Resident #81 the resident was observed with her lunch tray. When asked if she liked the food at the facility, the resident reported that the food in the facility was okay, but she wanted to wear her dentures when she eats. The writer asked if her dentures were with her in the facility and she stated, "Yes." Resident #81 was admitted to the facility on 08/22/18 with diagnoses including Cerebral Vascular Accident (CVA), Human Immuno-Deficiency Virus (HIV), Diabetes Mellitus, and Cognitive Communication Deficit. A review of the Quarterly Minimum Data Set (MDS) for Resident #81 dated 03/06/22 revealed	F 676	F 676 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED Residents residing in the facility with dentures and difficulty hearing have the potential to be affected by this practice. DON will conduct house wide audit to identify residents with hearing difficulties and ensuring that they have care plan in place to address hearing issue. The DON will also ensure that residents with dentures have them on and will validate if they are able to put them on without assistance, any issues found will be corrected and documented by 8/24/22.	8/24/22

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F 676	Continued From page 190 that facility staff coded the resident in the following manner: In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "03," indicating that the resident had severely impaired cognition. In Section G (Functional Status), ADL assistance: for personal hygiene, the resident was totally dependent and required physical assistance from one staff person. For eating/meals, the resident required limited assistance from one staff person. A review of Resident #81's medical record revealed: 08/23/18 (Date initiated) [Care Plan focus area]: [Resident #81] at risk for ADL Self-care deficit as evidenced by weakness to right side related to CVA. Interventions included: Assist with daily hygiene, grooming, dressing, oral care, and eating as needed ...Encourage to participate in self-care..." "Focus: [Resident #81] at risk for dental or oral cavity health problem related to health condition (CVA). [Resident #81] is edentulous. Interventions included assist with oral hygiene as needed..." 09/02/21[Denture Quality Assurance Checklist] documented: 1) Patient is satisfied with fit, 2) Patient is satisfied with esthetics, 3) Name is in the denture, 4) Denture kit given ... " 09/02/2021 [Dentist Note]: "...Patient satisfied with fit and esthetics..." 10/29/21 at 8:00 AM [Physician's Order]: "ST	F 676	F 676 MEASURES TO PREVENT RECURRENCE In service will be provided by Staff Educators to all licensed staff and nurse aides on the importance of ensuring that residents with dentures have them on and if need be, assist them in applying their dentures before meals by 8/24/22. In-service will be provided by Staff Educator to all nurses and CNA's to notify charge nurses if they notice that a resident cannot hear them while care is provided by 8/24/22 Unit Managers will ensure monthly that there is a care plan in place indicating that resident needs assistance with applying dentures. Any issues found will be corrected by 8/24/22. Residents who exhibit difficulties eating their meals will be assessed by the dentist for denture use. Any issues found will be corrected by 8/24/22. House wide audit will be conducted by Supervisors to ensure that there are no other residents with difficulty hearing. Any issues found will be addressed by 8/24/22	8/24/22

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F 676	Continued From page 191 (Speech Therapy) Strategies sit upright, alternate small bites/sips at slow rate, reduce distractions, check for pocketing, assist with cutting up meat, clear to cough/throat clear." 02/06/22 at 7:52 PM [Physician's Order]: "CHO (Consistent Carbohydrate Diet) regular texture, thin liquid consistency." During a second observation on 04/01/22 at 1:45 PM, Resident #81 was seen with her lunch tray. The resident was not wearing her dentures. When asked about the dentures, Resident #81 stated, "No one put them in for me." The evidence showed that facility staff filed to offer Resident #81 assistance with putting in her dentures at mealtimes. During a face-to-face interview on 04/01/22 at 1:51 PM, Employee #2 (Director of Nursing/DON) acknowledged that Resident #81's comprehensive care plan did not include assisting the resident with putting in her dentures at mealtimes and that she would update the care plan. 2. Facility staff failed to ensure Resident #82 was seen by audiology to address his ability to hear when communicating with others. During a face-to-face interview conducted on 03/29/2022 at approximately 10:00 AM, Resident #82 stated, "I can't hear. You have to come closer." No hearing assistive devices were observed on the resident or in his room. Resident #82 was admitted to the facility on 09/15/2021 with multiple diagnoses that included:	F 676	MONITORING CORRECTIVE ACTIONS DON/Designee will conduct house wide audit to ensure that residents with dentures have care plan in place, and those with difficulty to hear are scheduled to see the audiologist. This audit will be conducted weeklyx4, then monthlyx3, findings will be corrected, and report presented to QAPI committee	8/24/22

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F 676	Continued From page 192 Sensorineural Hearing Loss, Schizophrenia and End Stage Renal Disease. Review of Resident #82's medical record revealed: A Quarterly MDS dated 01/31/22 that showed facility staff coded a BIMS summary score, "14", indicating intact cognitive response. 09/21/21 [Physician's Orders] "Referral for Audiology consult 2/2 (secondary to) to pt (patient) reports of bilateral hearing loss impacting communication and quality of life 30 days" 09/21/21 (Created date) [Care Plan] "[Resident #82] has, impaired hearing function ... Arrange consultation with ear care practitioner as required..." Review of Resident #82's electronic and paper health record lacked documented evidence that the facility staff ever scheduled the resident for his audiology consult thus, impacting communication and quality of life. During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 (Clinical Coordinator) acknowledged the finding and stated that Resident #82 was never scheduled for the audiology consult appointment.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		

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F 677	Continued From page 193 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, for one (1) of 105 sampled residents, the facility's staff failed to provide Resident #113 showers. The findings include: During an observation on 03/29/22 at approximately 11:30 AM, Resident #113 was in bed and a certified nurse aide (CNA) had just finished providing am care. The resident was asked, how often does she receive showers, Resident #113 said, "I don't get showers. I just wash myself up in my bed." Resident #113 was admitted to the facility on 06/19/14. The resident has a history of General Muscle Weakness, Generalized Arthritis, Difficulty Walking, and Osteoporosis. Review of a Quarterly Minimum Date Set dated 02/09/22 showed the following: In section C (Cognitive Pattern) - the resident had a Brief Interview for Mental Status Summary Score of "15", indicating the resident had intact cognition. In section G (Functional Status) - Resident #113 was coded as needing supervision and set-up assistance with bathing, not steady and only able to stabilize with staff assistance during surface-to-surface transfers and using a mobility device (wheelchair). In section I (Active Diagnoses) the resident was	F 677	F 677 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT Resident # 113 was assessed from head to toe by Unit Manager on 4/26/22, resident is in no apparent distress. Resident was asked if she wanted to take shower on 6/13/22. Resident refuses a shower. Resident will continue to be offered and encouraged to take a shower. Documentation will be in place. Resident is the R/P. Any issues found will be addressed by 8/24/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED : All residents residing in the facility have the potential to be affected. Unit managers, Supervisors, Clinical coordinator , will make rounds to ensure that the residents are given shower on the days indicated in their plan of care. Any issues found will be addressed by 8/24/22	8/24/22

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F 677	Continued From page 194 coded for Generalized Muscle Weakness, Difficulty in Walking, and Chronic Obstructive Pulmonary Disease. Review of a care plan with a revision date of 12/09/19 showed the following: Focus Area - [Resident #113] has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) disease process CVA (Cerebral Vascular Accident). Interventions: provide [Resident #113] with basin and bathing supplies to promote independence, [Resident #113] supervision personal hygiene and oral care. Review of the shower schedule revealed the resident's scheduled shower days were on Tuesdays and Fridays on evening shift. Review of Skin Sweep Observation Sheets revealed the following: 04/01/22 (Friday) - the resident provided a bed bath 04/05/22 (Tuesday) - the resident provided a shower 04/07/22 (Friday) - the resident provided a shower During a face-to-face interview 04/12/22 at approximately 3:00 PM, Resident #113 stated that she was recently relocated to the unit, and she has not had a shower since her relocation "last year". When asked if she had a shower on 04/05/22 and not know where the shower room was located. When asked if she had a shower on 04/05/22 or 04/07/22 as document on skin sweep observation sheets? The resident said" Whoever that is lying bring them to me so I can tell them they are lying. I have not had a shower." The	F 677	F 677 MEASURES TO PREVENT RECURRENCE. In service will be provided by Staff Educators to all licensed and nurse aides on the importance of giving showers to the residents on the days indicated on their plan of care, that if a resident refuses, the CNA must notify the charge nurse. In-service will be completed by 8/24/22. Charge nurses will ensure the nurse aides are giving shower to the resident as indicated during their shift. Refusal of shower must be documented, and responsible party notified. The care plan must be updated to indicate non-compliance with care. Any issues found will be addressed by 8/24/22 Unit managers/ Designee will audit weekly to ensure documentation is in place when residents refuse to take shower. Any issues found will be corrected by 8/24/22 Random rounds will be conducted weekly by supervisors to ensure that the residents are given showers on their due date. Any issues found will be corrected and responsible party updated by 8/24/22	8/24/22

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F 677	Continued From page 195 resident stated, "I would love a shower." During a face-to-face interview on 04/12/22 at approximately 3:15 PM, Employee #56 (Certified Nursing Assistant -CNA) stated that she worked with Resident #113 on the evening shift for about a year and she had never given the resident a shower. The employee said that she set the resident supplies up for the resident to give her own bed bath. During a face-to-face interview on 04/12/22 at approximately 3:30 PM, Employee #57 (CNA) stated that she worked the resident for about 8 months on the evening shift. The employee said, "She (Resident #113) doesn't take shower." The employee was then asked how does get her scheduled showers? The employee said, "I put hot water in a bowl" for her.	F 677	MONITORING CORRECTIVE ACTIONS ADON//Designee will conduct rounds to ensure that residents are having showers as indicated in their plan of care. This audit will be carried out weekly x4, then monthly x3,findings will be corrected, and report presented to QAPI committee.	8/24/22
F 684 SS=E	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 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 observation, record review, family interview and staff interview, for four (4) of 105 sampled residents, the facility's staff failed to ensure that residents received treatment and care in accordance to the physicians' order and	F 684	F684 CORECTIVE ACTION FOR THE AFFECTED RESIDENTS. Resident # 3 was discharged home on 3/29/22 Resident # 50 was assessed from head to toe by Unit manager resident suffered no negative outcome. MD/ RP notified on 4/26/22 care plan for two persons with ADL is ongoing Resident # 82 was assessed by unit manager on 4/26/22, resident suffered no negative outcome. Will schedule an Audiology consult no later than 8/9/22 .Resident taken into custody by DC police on 7/20/22 Resident #181 was assessed on 4/26/22, resident suffered no negative outcome.MD/RP notified on 4/26/22. Resident is receiving her medication via inhaler correctly monitored by Unit manager and supervisor weekly.	

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F 684	Continued From page 196 the comprehensive person-centered care plan as evidenced by: failed to provide stoma site for one (1) resident; failed to schedule one (1) resident for an audiology consult appointment; failed to implement the care plan intervention of having two (2) certified nurse aides (CNAs) for activities of daily living (ADLs) for one (1) resident; and failed to administer nebulizer inhaler as ordered the physician's order for one (1) resident. (Residents' #3, #50, #82 and #181). The findings include: 1. The facility's staff failed to follow standards of practice by not providing stoma care for Resident #3 from 12/01/21 to 02/06/22. Review of an intake form for a complaint received by the DC Department of Health, Health Care Regulation and Licensing Administration on 01/26/22 showed the complainant [granddaughter] alleged that on every visit with Resident #3 she and her mother (residents responsible party) had to "clean my grandfather's stoma...no one at the facility does his [stoma] cleaning." The complaint also alleged "I have photos of my grandfather's neck with days old, dried secretion and multiple bouts of mucus plugging." According to Johns Hopkins, "... the buildup of mucus and the rubbing of the tracheostomy tube can irritate the skin around the stoma. The skin around the stoma should be cleaned at least twice a day to prevent odor, irritation and infection. If the area appears red, tender or smells badly, stoma cleaning should be performed more frequently..."	F 684	F 684 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED, Residents residing in the facility with a stoma site, residents requiring two CNA's for ADL care, residents with hearing difficulties and those using inhaler medication have the potential to be affected by this practice, Supervisors/ Designee will conduct house wide audit to ensure that nurse aides are providing ADL care as indicated in the resident plan of care, those with hearing problems are scheduled to see the audiologist and that medications are administered per standard of practice. Any issues found will be addressed by 8/24/22	8/24/22

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F 684	Continued From page 197 https://www.hopkinsmedicine.org/tracheostomy/living/stoma.html Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of Resident #3's medical record revealed the following: 12/01/22 - 02/06/22 [nursing progress notes]- lacked documented evidence nursing staff provided stoma site care. 12/01/22 - 02/06/22 [medication administration records] - lacked documented evidence nursing staff provided stoma site care. 12/01/22 - 02/06/22 [treatment administration record] - lacked documented evidence nursing staff provided stoma site care. 12/02/22 [physician's order] instructed, cleanse lari (lary)-tube daily on day shift. 02/07/22 [physician's order] instructed, please clean, and remove crusting from in and around the stoma BID (two-times-a day) with moist gauze and sterile ... Review of an Admission Minimum Data Set dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank. Additionally, the resident was coded for receiving Tracheostomy care and speech therapy services. Continued review showed that Resident #3 was not coded for receiving respiratory therapy	F 684	F 684 MEASURES TO PREVENT RECURRENCE In-service will be provided to nurse aides by Staff Educator /Designee to ensure that care is provided based on the president's plan of care by 8/24/22. Staff Educator will ensure that the nurses understand how to administer inhaler medication. Return demonstration and completion of medication administration check list will be in place by 8/24/22. Unit managers will ensure that residents with hearing problems are schedule to see the Audiologist by 8/24/22. Unit Managers will ensure that C N A's are implementing care based on the interventions on the residents' plan of care especially when it comes to ADL care. Any issues found will be corrected by 8/24/22. Unit Managers will audit weekly to ensure that charge nurses are administering inhaler medications per standard of practice. Any issues found will be corrected by 8/24/22 In service will be provided by staff educator to all licensed nursing staff on how to provide care to a resident with stoma and also how to perform CPR on a resident with stoma by 8/24/2022.	8/24/22

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F 684	Continued From page 198 services. Care Plan Review of the comprehensive care plan with an initial date of 12/04/21 showed the following: Focus Area-[resident's name] has lary tube r/t (related to) laryngeal cancer. Goal-[resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed... Further review of Resident #3's comprehensive care plans lacked documented evidence of interventions to address care for stoma site from 12/01/22 to 02/06/22 . During a telephone interview on 04/12/22 at 11:35 AM, the resident's emergency contact (granddaughter) stated that when she visited Resident #3 at the facility, she would often notice his stoma with crusty secretions. She also stated that when she would visit him at the radiation/chemotherapy infusion site Resident #3 stoma site and lary-tube were dirty frequently. She said a few times that the radiation/chemotherapy infusion center had to clean the stoma site and lary-tube before they could render care. The granddaughter then stated that she had multiple pictures as evidence of her concerns. During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated that when staff cleaned Resident #3's lary-tube daily they provided care to the resident's stoma site. Employee #7 then said, "I have care	F 684	F 684 MONITORING CORRECTIVE ACTIONS DON/Designee will conduct house wide audit to ensure that residents care plan for ADL care are implemented as indicated in their plan of care, that resident who are scheduled for Audiology appointment go for the appointment as scheduled and that medications are administered as indicated by the physician. That residents with stoma site have care implementations in place. This audit will take place weekly x4 and then monthly x3. Findings will be corrected, and report presented to QAPI committee.	8/2422

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F 684	Continued From page 199	F 684		8/24/22

for the lary-tube in the care plan. I just didn't add stoma site care."

2. Facility staff failed to implement the care plan intervention of having two (2) CNAs for ADLs for Resident #50.

Review of a Facility Reported Incident (FRI) received on 11/22/21, documented, "...allegation made by [Resident #50] on 11/15/21 that at 11:30 AM, a CNA ... hit her 6 times on her left knee with a bar of soap wrapped in a towel ..." The CNA ...was interviewed; she said she went to resident's room at 9:20PM and asked her if she was ready to be changed and Ms. Lambright said yes. The CNA said she called the nurse to come and assist her because resident is two persons assist, but resident refused two persons to provide care to her; the CNA then said she proceeded to provide incontinent care to resident ..."

Resident #50 was admitted to the facility on 06/26/14 with multiple diagnoses that included: Morbid Obesity, Anxiety Disorder, Mood Affective Disorder and Major Depressive Disorder.

Review of Resident #50's medical record revealed the following:

Review of Resident #50's Quarterly MDS dated 09/24/21 showed that facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of "13", indicating intact cognition.

01/30/20 (Revision date) [Care Plan] "[Resident #50] has an ADL (activities if daily living) self care performance deficit r/t (related to) limited ROM

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(range of motion), limited mobility, morbid obesity ... the resident requires 2 staff participation to reposition and turn in bed, the resident requires total assistance with personal hygiene care ..."

11/16/20 (Creation Date) "Alleged abuse ... 2 CNAs (Certified Nurse Aides) to provide ADL care all shift ..."
11/17/2020 [Physician's Order] "2 CNAs to provide ADL care all shift"

03/01/21 (Revision date) [Care Plan] "[Resident #50] is resistive/noncompliant with treatment/care ... Allow for flexibility in ADL routine to accommodate mood, preferences, and customary routine ..."

11/16/21 at 9:40 AM [Nurses Note] "At around 9.30 PM (11/15/2021),the CNA ... called the writer to room 229 B because [Resident #50] was refusing her to finishing cleaning her. Upon entering the room, the writer found [Resident #50] shouting, cursing the CNA alleging that the CNA hit her on the thigh. The writer assessed the resident and there were no signs of hitting nor was she in any pain or distress ...The writer released the CNA and called CNA ... to help finish cleaning the resident ..."

The evidence showed that facility staff failed to follow the care plan interventions of having two CNAs for ADL care of Resident #50 on the evening shift (3:00 PM to 11:00 PM) on 11/15/21.

During a face-to-face interview conducted on 04/12/22 at 10:00 AM, Employee #7 (Clinical Coordinator) acknowledged the finding and made no comment.

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F 684	Continued From page 201	F 684		8/24/22

3.Facility staff failed to implement the care plan intervention of scheduling Resident #82 for an audiology consult appointment.

Resident #82 was admitted to the facility on 09/15/21 with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss.

Review of Resident #82's medical record revealed:

A Quarterly MDS dated 01/31/22 that showed facility staff coded a BIMS summary score, "14", indicating intact cognitive response.

09/21/21 [Physician's Orders] "Referral for Audiology consult 2/2 (secondary to) to pt (patient) reports of bilateral hearing loss impacting communication and quality of life 30 days"

09/21/21 (Created date) [Care Plan] "[Resident #82] has, impaired hearing function ... Arrange consultation with ear care practitioner as required..."

Review of Resident #82's electronic and paper health record lacked documented evidence that the facility staff ever scheduled the resident for his audiology consult.

During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 acknowledged the finding and stated that Resident #82 was never scheduled for the audiology consult appointment.

4. Facility staff failed to administer Resident

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F 684	Continued From page 202	F 684		8/24/22

#181's Tiotropium Bromide Monohydrate (Spiriva) Aerosol Inhaler
as ordered and per standards of practice.

Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease.

A. During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer the inhaler for Resident #181. It should be noted the resident received the medication (inhaler) in the presence of the unit manager and surveyor.

Review of a physician's order dated 03/18/22 instructed, Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhaler orally one time a day for COPD (Chronic Obstructive Pulmonary Disease).

Employee #45 signed her initials indicating that she administered Resident #181 Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally at 9:00 AM on 03/18/22, 03/21/22-3/24/22, and 03/26/22 - 03/28/22. Subsequently, Resident #181 did not receive 8 of 12 doses of Tiotropium Bromide Monohydrate Aerosol Solution inhaler since it was ordered on 03/18/22.

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Employee #45 signed her initials indicating that she administered Resident #181 Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally at 9:00 AM on 03/18/22, 03/21/22-3/24/22, and 03/26/22 - 03/28/22. Subsequently, causing Resident #181 to miss 8 of 12 doses of the medication since it was ordered on 03/18/22.

Review of Treatment Administration Record and Vital Summary sheet documented that Resident #181's oxygen saturation rate ranged from 96-98% on room air from 03/18/22 to 03/21/22 and respiration rate ranged from 17 to 20 breaths per minute from 03/18/22 to 03/24/22.

During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that 03/29/22 was the first time she administered Tiotropium Bromide Monohydrate Aerosol inhaler because she did not know how to administer it. When ask why did she initial that she administered prior to 03/29/22? She said, "It was an error." The employee also said that she did not make anyone aware she did not know how to administer that type of inhaler.

Employee #45 failed to administer Resident #181 Tiotropium Bromide Monohydrate Aerosol inhaler as ordered from 03/18/22 to 03/24/22.

B. During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering Resident #181 Symbicort inhaler two puffs and Tiotropium inhaler two spays inhaler without having the resident rinse her mouth after administration.

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F 684	Continued From page 204 According to the manufacture, "Symbicort may cause serious side effects, including Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush...." https://www.mysymbicort.com/asthma/side-effects.html According to Medline, "... after using your inhaler, rinse your mouth with water, gargle, and spit. Do not swallow the water. This helps reduce side effects from your medicine..." https://medlineplus.gov/ency/patientinstructions/000041.htm Review of a physician orders revealed the following: 03/18/22 - Budesonide-Formoterol Fumarate (Symbicort)Aerosol 160-4.5 mg/ACT 2 puff inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disorder) 03/18/22 - Tiotropium Bromide Monohydrate (Spiriva) Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease). During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that she forgot to have the resident rinse her mouth after using each inhaler. Employee #45 failed to follow standards of practice when administering metered dose inhalers for Resident #181.	F 684		8/24/22

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F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, for one (1) of 105 sampled residents, facility staff failed to ensure that Resident #82 received assistive devices to maintain hearing ability. The findings include: During a face-to-face interview conducted on 03/29/22 at approximately 10:00 AM, Resident #82 stated, "I can't hear. You have to come closer." No hearing assistive devices were observed in the resident ' s ear or in his room. Resident #82 was admitted to the facility on 09/15/21with multiple diagnoses that included: Sensorineural Hearing Loss and Schizophrenia. Review of Resident #82's medical record revealed: A Quarterly Minimum Data Set (MDS) dated	F 685	F685 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT Resident# 82 has been scheduled to see the audiologist for assessment and treatment for hearing difficulties on 6/23/22.Resident taken into custody by DC police on 7/20/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Resident with hearing problems have the potential to be affected by this practice. Unit Managers conducted rounds on their units to identify residents with hearing problems and to ensure they are scheduled to see the audiologist. Any issues found will be corrected by 8/24/22. MEASURES TO PREVENT RECURRENCE Nurses will be encouraged to pay close attention during their shift to the residents on their units to ensure residents with difficulty hearing are scheduled for audiology consult. Any issues found will be addressed by 8/24/22 In-service will be provided to all licensed nurses, C N A 's, Unit Secretaries on the importance of scheduling appointments in a timely manner by the Staff Educator no later than 8/24/22.	8/24/22

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F 685	Continued From page 206 01/31/22 that showed facility staff coded a Brief Minimum Interview for Mental Status (BIMS) summary score, "14", indicating intact cognitive response. 09/21/21 [Physician's Orders] "Referral for Audiology consult 2/2 (secondary to) to pt (patient) reports of bilateral hearing loss impacting communication and quality of life 30 days" 09/21/21 (Created date) [Care Plan] "[Resident #82] has impaired hearing function ... Arrange consultation with ear care practitioner as required ..." Review of Resident #82's medical record lacked documented evidence that the facility staff ever scheduled the resident for his audiology consult thus, impacting communication and quality of life. During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 (Clinical Coordinator) acknowledged the finding and stated that Resident #82 was never scheduled for the audiology consult appointment.	F 685	F 685 MONITORING CORRECTIVE ACTION DON/Designee will conduct house wide audit to ensure that residents with hearing problems see an audiologist. This audit will be conducted weeklyx4 then monthly x3, findings will be corrected, and report presented to QAPI committee	8/24/22
F 689 SS=H	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		

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F 689	Continued From page 207 by: Based on observation, record review, resident, family and staff interviews, for 11 of 105 sampled residents, the facility's staff failed to ensure that residents received adequate supervision as evidenced by failure to 1. ensure that Resident #404 received adequate supervision to prevent an altercation with Resident #82, resulting in serious injury, 2. provide adequate supervision for Resident #56 who sustained a fall outside in front of the facility resulting in serious injury, 3. provide Resident #409 who was status post hip surgery with adequate supervision to prevent an injury of unknown origin (dislocated hip), 4. provide adequate supervision of Resident #151 to prevent altercations with Residents #71 and #67, 5. properly secure Resident #183's wheelchair during a van transport, resulting in a fall with injury, 6. provide adequate supervision of Resident #61 to prevent multiple falls with an injury, and 7. provide adequate supervision and monitoring of Resident #72 to prevent an altercation with Resident #188. Actual harm was determined for residents #404, #56, #409, #67, and #183. The findings include: Review of the facility policy entitled, "Resident-to-Resident Altercation/Incidents" revised in 01/2022 documented, " ... When a resident is observed or identified as being aggressive to having aggressive behavior or has the potential for abusing other residents, an assessment of strategies to prevent such incidents from occurring will be provided by the Interdisciplinary Team (IDT) ... These immediate actions may include ... monitor and adjust care to	F 689	F 689 CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENTS. Resident # 404 was sent to the hospital on 2/21/22, did not return to the facility. Resident # 82 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/ RP notified on 4/26/22. Resident is on 1;1 monitoring and supervision until seen by psychiatry doctor. Resident taken into custody by DC police on 7/20/22 Resident # 56 was assessed from head to toe on 4/7/22, resident suffered a hematoma on the left forehead.MD/RP notified on 4/7/22. An employee has been assigned to monitor residents at the front of the building. The front access site of the building has been blocked with poles, to prevent resident from rolling into the parking lot. Residents' ability to use wheelchair will be assessed by Rehab team. Resident #61 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident will be taken to the day room A for monitoring every shift secondary to multiple falls. Resident # 72 was assessed from head to toe by Unit manager on 4/26/24. Resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident will be taken daily to the day room B for monitoring every shift. He is on the fifth floor now. Resident # 188 was assessed from head to toe on 4/26/22. Resident suffered no negative outcome. MD/RP notified on 4/26/22, resident is on the fourth floor	8/24/22

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F 689	Continued From page 208 reduce negative outcomes ... aggressor placed on 1:1 monitoring ... the care plan will be updated with the interventions in place to prevent and deescalate behaviors by the licensed nurses/manager..." 1. Facility staff failed to ensure Resident #404 received adequate supervision to prevent an altercation with Resident #82, resulting in serious injury. Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, "...The charge nurse observed [Resident 404] sitting on the floor besides his roommate's ... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..." Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's Name]... in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..." Review of a Complaint dated 03/31/22 documented, "...Avoidable death. Comments: Patient assaulted in nursing home. Beneficiary was assaulted 02/22/2022 in skilled nursing facility by another resident. He sustained blunt	F 689	Resident # 151 was assessed from head to toe on 4/26/22. Resident suffered no negative outcomes. . MD/RP notified on 4/26/22. Resident is on 1;1 monitoring and supervision until reassessed by psych doctor/or until further notice. Resident # 183 was assessed from head to toe on 4/26/22, resident suffered no negative outcomes. MD/ RP notified on 4/26/22. Bus driver has been trained on the importance to keep resident safe in the van while transporting them. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED All residents residing in the facility have the potential to be affected by this deficient practice. DON/Designees will conduct rounds weekly to ensure that residents are monitored and always supervised. Any issues found will be corrected by 8/24/22	8/24/22

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F 689	Continued From page 209	F 689	MEASURES TO PREVENT RECURRENCE	~~8/24/22~~

head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died ..."

Resident Background Information:

A. Resident #82 was admitted to the facility on 09/15/21 with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss.

Resident #82's Quarterly Minimum Data Set (MDS) dated 01/31/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating intact cognitive response, no physical or behavior symptoms directed towards others, required supervision with one person physical assist for activities of daily living (ADLs), used a walker for mobility and received antipsychotic medications.

B. Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack.

Review of Resident #404's medical record revealed the following:

12/16/21 [Quarterly MDS] showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment.

In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others

In- service will be provided by Staff Educator to all nursing staff to ensure that residents are monitored and supervised by 8/24/22.

Unit Mangers/Designee will ensure that all residents on their units are accounted for during their shifts. Any issues found will be addressed by 8/24/22.

Supervisory lobby employee will ensure that residents sitting outside are supervised. Findings will be reported to the front desk who will call the unit for the nurse to come and address the issue immediately.

Hourly rounds will be made by staff members during their shift to ensure that residents are not left alone in a situation that can lead to a fall. Any issues found will be addressed by 8/24/22.

The facility van driver was provided training on van safety on 6/7/22. The driver will ensure that the residents are safe in the van during transportation.

C.N.A /escort riding with the resident are encouraged to ensure that the residents are safe in the van. Any issues found will be addressed by 8/24/22.

Charge nurse will place aggressive and uncontrolled resident on 1:1 until assessed by Psychiatrist doctor for treatment modalities.

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F 689	Continued From page 210 sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily" In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion In Section P (Restraints and Alarms), wander/elopement alarm, "Used daily" Care Plan: 07/27/21 (Revision date) ["Resident #404 is at risk for Elopement: cognitive impairment, dementia ... Observed wondering at the adjacent unit on 5/28/2021. Wandering to the adjacent unit on 7/3/21. Redirected easily. Wandering to the adjacent unit on 6/8/2021. Easily redirected. Wondering on 7/11/2021. Redirected. Wondering to the adjacent unit 7/27/2021, Easily redirected ... Avoid leaving unattended or unobserved for long periods of time. Hourly elopement/wandering monitoring and location." Review of the Daily Behavior Documentation showed the following: 02/02/22 at 2:12 PM "... Elopement attempts. Wandering ....sleeping in other people's bed... Behaviors are constant." 02/03/22 at 1:12 PM "... sleeping in other people bed. Behaviors are constant." 02/07/22 at 1:52 PM "... sleeping in other people's	F 689	Charge nurses will also ensure that residents who wander are supervised and redirected during their shift and put documentation in place to justify supervision. Findings will be corrected by 8/24/22. Charge nurse/ Rehab staff will assess resident who fell secondary to trying to pick something from the floor for need of a Reacher and will be provided by 8/24/22 if applicable. In service will be provided to all CNA's/escorts by staff educators on the importance of ensuring that the residents are safe while riding the van by 8/24/22. In service will be provided by staff educator to all activities staff on how to use the wheelchair breaks while the resident is sitting on it.	8/24/22

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F 689	Continued From page 211 bed. Behaviors are constant." 02/09/22 at 1:47 PM "...sleeping in other peoples bed. Behaviors are constant." 02/10/22 at 12:17 PM "...sleeping in other peoples bed...Behaviors are constant." 02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant." 02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant." 02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant." 02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant." 02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant." 02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant." Skin Observation Tool dated 02/21/22 at 2:40 AM documented, "Observations... face... Blood was coming from his mouth, we managed to stop it by applying cold compress and ice..." Situation Background Assessment Request (SBAR) dated 02/21/22 at 4:00 AM showed, "Situation... The resident got hit by his roommate... Background: Altered mental status... Resident Reports Pain? 'No'. Non-verbal	F 689	MEASURES TO PREVENT RECURRENCE CONT Resident # 56 will be assessed for smoking by charge nurse and her care plan will be updated to reflect her smoking needs by 8/24/22 . Education will be provided by Staff educator to all licensed nurses on the importance of assessing all residents who smoke monthly and update their care plans to reflect their current situation. Unit manager will ensure that resident #61 will be supervised while resident is on the wheelchair during their shift by C N A 'S, findings will be addressed by 8/24/22. Charge nurses must ensure that residents who fall during their shift are assessed for pain and medicated as ordered by the physician. Also, complete an incident report for fall. Findings will be corrected by 8/24/22 Unit Manager will ensure that residents with aggressive behaviors are supervised during their shift and that residents are not placed close to each other to help prevent altercations. Resident # 72 will not be placed close to resident #188., likewise resident # 71 and # 67. Residents are on different units. Resident #72 is on the fifth floor, resident #188 is on the fourth floor Resident #151 is in a private room with one-on-one continuous monitoring for aggressive behavior	8/24/22

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F 689	Continued From page 212 indicators of pain evident? 'No'. Functional Status unchanged... Skin/Wound Status- (area was left blank) ... Assessment ... (area was left blank) ... Additional comments ... At approximately 02:30 am ... The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face. The writer immediately notify the supervisor and called 911. DC (District of Columbia) police. I saw [Resident #82] also sitting on his walker facing [Resident #404]. The writer asked [Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware." 02/21/22 at 4:16 AM [Nursing Supervisor Progress Note] "The Charge Nurse reported that While making routine rounds, Resident [#404] was observed sitting on the floor beside Room 420 A. Resident was noted with some blood on the left side of his face, a quick assessment was made, he was assessed for pain and discomfort. Resident could not describe what happened. This is his base line. A quick assessment was done, Range of motion exercise was done, ice was applied to the left side of the face, vital signs was monitored T. (temperature) 96.5, P. (pulse) 82, R. (respirations) 18, B.P. (blood pressure) 140/90, Spoe (sp) (oxygen saturation) 97% on Room Air." 02/21/22 at 1:43 PM [Nurses Note] "A call was placed to [Hospital Name] to know about the status of the resident [#404] in the ER, spoke with nurse [Registered Nurse's Name] who stated resident (#404) is critically ill, he has been	F 689	MONITORING CORRECTIVE ACTION DON /Designee will conduct frequent rounds during their shifts to ensure that the residents are adequately supervised for safety reasons. This audit will be conducted weekly x4 then monthly x3. Findings will be corrected and reported to QAPI Committee.	8/24/22

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F 689	Continued From page 213	F 689		8/24/22

intubated and about to be transferred to ICU (intensive care unit). RP ... made aware."

During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, "... Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D [Resident #404] Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed ..."

This evidence showed that facility staff had knowledge of and documented Resident #404's intrusive behavior of going into other residents rooms and sleeping in other resident's beds.

a. Although the facility had a care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revised to address the residents intrusive behavior (wandering into other resident rooms and sleeping in their beds).

b. Facility staff failed to document the names, room numbers of residents who were affected by Resident #404's behavior; and failed to assess how Resident #404's behavior impacted other residents such as putting himself or others at risk for physical injury, intrusion on their privacy or activity, upset that he in their room and sleeping in their bed.

c. Although the staff record that Resident #404 was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that monitoring the resident was readjusted to

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F 689	Continued From page 214	F 689		8/24/22

manage the residents behavior.

During a face-to-face interview conducted on 04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) stated, "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make updates as needed." When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in other resident's beds, Employee #7 stated, "I was never made aware by the nurses on the unit. I knew him [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation ..." that stated Resident #404's behavior, Employee #7 stated, "I didn't see it."

2. Facility staff failed to provide adequate supervision for Resident #56 while in the front of the building in the non-smoking area, resulting in injury.

Review of the facility incident report submitted to DC Department of Health dated 04/07/22 read as follows: "[Resident Name] ...with a BIMS score of 15 who presents with COPD, Diabetes, Heart Failure, [Hypertension], and [End Stage Renal Disease]. On April 6, 2022, around 17:15, resident was observed outside, in the parking lot, and on the floor. Upon the initial assessment, resident was observed with a hematoma to the left side of her forehead. When asked what occurred, she informed the staff that she was

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F 689	Continued From page 215	F 689		8/24/22

attempting to get something off the floor and slid out of her wheelchair. She was assessed and did not have any complaints of pain. She was then assisted back into the wheelchair and taken up to her room for further interventions and assessments. Neuro check was conducted, and everything was within normal limits ...CRNP (Certified Registered Nurse Practitioner) was made aware of the fall and an order was obtained to transfer the resident to the hospital for further evaluation. 911 was called ...arrived at the facility ...to take the resident to the hospital. Resident was transferred to [Name of Hospital] ...Care plan updated for resident to seek assistance with retrieving items from the floor while in the wheelchair and she was educated on the importance of not bending over while in the chair for safety ..."

Resident #56 was admitted to the facility on 11/20/19 with diagnoses which included End Stage Renal Disease, Hypertension, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Acquired Absence of Right and Left Leg Below the Knee.

The Quarterly MDS dated 01/22/22 under section C0500 BIMS Score showed Resident #56 was coded as a "15" indicating that she was cognitively intact. Under Section E Behavior, the resident was coded as no behaviors exhibited. Under Section G Functional Status, the resident was coded as requiring extensive assistance with one-person physical assist under bed mobility, locomotion on and off unit, dressing and personal hygiene. Under Section G0400 Functional Limitation in range of motion, the resident was coded as having impairment on both sides of lower extremities. Under G0600 Mobility Devices,

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the resident was coded as using a wheelchair.

Review of the nursing progress notes read as follows:

04/06/22 at 12:19 PM "... [Employee #22 (Activities Aide)] was coming from the patio when she observed resident's wheelchair suddenly rolling into the parking lot. The Security chased after the wheelchair and resident, but resident ran into a car and fell. Resident said during interview, 'My wheelchair suddenly started rolling from the building into the parking lot, I was unable to stop it and into a car and hit my head." Head to toe assessment done; A hematoma was observed on the left forehead. No skin tear, no bleeding, no discoloration observed. Denied pain ...NP (Nurse Practitioner) ...was notified and she gave an order to transfer to the nearest ER ..."

04/07/22 at 11:04 AM [Nurse Practitioner Progress Note] "...seen today for assessment s/p fall and f/u (follow up) ER visit ...While in the ER, she had a negative head scan and negative right knee X-R (Xray), and she was sent back to the facility this morning to continue rehab and acute care."

04/07/22 at 11:40 AM "Resident returned from [Hospital Name] at 10:15 AM in stable condition S/P (status post) fall. On assessment, swelling remains on left forehead with discoloration noted. Nose bleeding observed. Resident is alert and responsive. Denied pain. Able to communicate. Per hospital transfer records, a head CAT (computed tomography) Scan was don which demonstrated no evidence of brain injury."

A face-to-face interview with Resident #56 was

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conducted on 04/08/22, at approximately 10:30 AM. She stated that someone from Activities Department was helping her outside (pushing her wheelchair). The staff member did not put the brakes on the wheelchair. The wheelchair rolled down and she hit her head on the concrete after the wheelchair hit a car and she fell over.

During a face-to-face interview with Employee #22 (Activities Aide) on 04/08/22, at approximately 2:15 PM. He stated, "I am the staff member who helped [Resident #56] with her wheelchair on 04/05/2022 (date of the incident). Employee #22 and I (writer) proceeded outside the facility, and he showed me where he left [Resident #56], on the day of the incident (04/06/2022). Employee #22 and I turned left at the front door of the facility and walked a few steps past the guardrails, towards the smoking area. He stopped between the fourth and fifth guardrail and pointed to an area with a yellow arrow on the ground and identified it as the spot where le left the resident. He said that the resident told him she had it from there. He left and went inside and within minutes, he turned around and saw [Resident #56's] wheelchair rolling down the parking lot. He ran to try to catch her and her wheelchair, but it was too late. [Resident #56's] wheelchair hit a car that was parked at the far-right corner (third row of the parking lot), and she fell out of the chair onto the concrete.

During an interview with Resident #56 on 04/11/22 at 11:30 AM, she stated, "I can lock and unlock the wheelchair. I can roll myself outside. I was coming from Bingo. I asked to go outside. They pushed me outside in front of the building. He (Employee #22) did not put the locks on the

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wheelchair, and he took his hands off the wheelchair. He did not push me when he let go of the wheelchair. I know how to put the locks on the wheelchair. I was outside when the incident happened."

During an interview with Resident #56 on 04/13/22 at 11:40 AM, she stated, "I did not turn the wheelchair around after the staff member left."

During an interview on 04/13/22 at 12:20 PM, Employee #22 said that he normally locks the wheelchair before he leaves a resident but did not lock [Resident #56's] wheelchair on 04/06/22, because she was heading to the smoking area, they had not gotten to that area when she told him ... "I got it from here". He said that he thinks [Resident #56] turned her wheelchair around after he left her to head to the other side of the building where her friend [Resident #80] was.

At the time of the incident, there was no evidence that facility staff provided adequate supervision for Resident #56 and other residents who were in the front of the building in the non-smoking area. Subsequently, Resident #56 was observed seated in her wheelchair, rolling through the parking lot, hit a parked car (approximately 40 feet away from the sloped sidewalk at the entrance of the building), fell out of her wheelchair and sustained a hematoma to the left side of her head.

Additionally, there was no evidence that facility assessed the seating device (wheelchair) used by Resident #56 to determine if it was personal fit and safe for the resident to use.

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Lastly, although the facility staff states that Resident #56 is a smoker, she was not identified as a smoker and there was no smoking assessment or care plan in place to address the resident smoking.

During a face-to-face interview with Employee #30 (Director of Rehabilitation Department) on 04/13/22, at 2:20 PM, she confirmed a wheelchair assessment was not completed for Resident #56 and provided documentation to show that a wheelchair referral was initiated on 04/10/22.

During a face-to-face interview with Employee #7 on 04/20/22 at 10:28 AM, he stated, "Prior to this incident, Resident #56 was not assessed for a wheelchair. Prior to this there was no escort. I didn't know she was going outside and the facility staff said they didn't know she was going outside. The resident is free to go outside. So we put interventions in place so this doesn't happen again."

During a face-to-face interview with Employee #2 (Director of Nursing) on 04/20/22 at 10:28 AM, she stated, "She [Resident #56] was wheeling herself to smoke. He [Employee #22] was trying to wheel her to go smoke. When she turned around to go back she loss control of her wheelchair. He [Employee #22] saw her two minutes later and chased after her."

3. Facility staff failed to provide adequate supervision as specified in Resident #61's care plan resulting in the resident having multiple falls.

Review of the FRI received on 10/21/22 documented, "Writer was notified at 1405 (2:05 PM) by the receptionist at the front desk that

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resident is observed lying face down at the entrance of the facility ... Resident reported to writer that 'I hit the wheel of my wheelchair against a surface and fell off my wheelchair and hit my head on the ground and my head hurts". ...right side of his forehead noted with an abrasion with no bleeding/swelling observed at this time... transfer resident to the nearest ER via 911 for further assessment ..."
Resident #61 was admitted on 11/06/20 with multiple diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Anemia, Hypertension, Acute Kidney failure, Systemic Inflammatory Response Syndrome and Anxiety.

Review of Resident #61's medical record revealed the following:

A Quarterly Minimum Data Set (MDS), with an Assessment Reference dated 09/09/21 that documented the following:

In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "09", indicating moderate cognitive impairment.

In Section E (Behavior), no indicators of psychosis, rejection of care, or wandering.

In Section G (Functional Status), supervision with the assistance of one person for locomotion on the unit (how the resident moves, between locations in his/her room and an adjacent corridor on the same floor. If in a wheelchair, self-sufficiency once in the chair) and locomotion off the unit (how the resident moves to and returns from off unit locations (e.g. areas set aside for dining, activities, or treatments).

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In Section J (Health Conditions), one (1) fall with injury (skin tears, abrasions, lacerations. Superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain) since admission/entry/reentry (11/06/2020).

A care plan with a start date of 11/07/20 showed, "At risk for fall" due to history of falls, unsteady gait, cognitive impairment, unstable health condition, pain, poor coordination, Diseased process ...and impaired balance. Goal: Resident will remain free of injury from falls through the next review date. Interventions: Assess for fall risk on admission quarterly and as needed. Bed in low position."

10/17/21 at 7:11 PM [Progress Note] "Writer was notified at 1405 (2:05 PM) by the receptionist at the front desk that resident is observed lying face down at the entrance of the facility. Writer rushed outside and observe resident lying face down. Resident is alert and verbally responsive. Resident reported to writer that 'I hit the wheel of my wheelchair against a surface and fell off my wheelchair and hit my head on the ground and my head hurts". Resident denies any other distress at this time ...resident verbalized pain on his head on a scale of (1-10) 9/10 ... resident's right side of his forehead noted with an abrasion with no bleeding/swelling observed ... MD (medical doctor) made aware ... transfer resident to the nearest ER (emergency room) via 911 for further assessment. .."

11/26/21 at 11:36 PM [Nurses Note] "At about 10:10 pm staff heard a loud noise at the hall in front of room 204. When staff went to check, they

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observed resident on the floor in laying position on his left side in front of his wheelchair ... Resident c/o (complained of) of having severe pain to the left [side of] forehead, no discoloration or swelling noted to the site ... DC (District of Columbia) EMS (emergency medical services) called non-emergency ambulance to transport resident ..."

11/27/21(Revision date) [Care Plan with focus area] "Actual fall on 10/17/21 with a right forehead abrasion, 11/24/21 fall with no injury, 11/27/21 fall with no injury at the front lobby." Goal: Resident will not speed when moving around in his wheelchair through the next review date. Interventions: Staff will make frequent rounds to resident's room to constantly remind resident to use the call button to call staff for assistance. Increased staff supervision with intensity based on residents' needs. Bed alarm in place. PT (physical therapy) consult for strength and mobility. Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bed-bound..."

11/27/21 at 1:55 PM [Nurses Note] "Resident alert and verbally responsive. He returned from ER ... at 1:35pm (1:35PM) in stable condition... Resident denied pain. CT (computed tomography) scan of the head and face indicated no acute fracture ..."

Review of Resident #61's the medical record from 10/17/21, through 11/25/21, showed there was no documented evidence that there was an "increase in staff supervision with intensity" based on residents' needs as directed in the care plan (created dated 10/18/2021). Resident #61 sustained another fall on 11/26/21 with minor

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injury.

During a face-to-face interview conducted on 04/19/21 at 9:30 AM, with Employee #8 (2nd Floor Unit Manager) acknowledged the finding and stated, "He [Resident #61] is not supervised or monitored. He [Resident #61] goes off the unit by himself and always returned with no problem."

4. Facility staff failed to provide adequate supervision and monitoring of Resident #72's location, resulting in a resident-to-resident altercation with Resident #188.

Review of a facility reported incident dated 03/30/22 documented, "...according to the Charge nurse on the unit and the CNA, ...When the two of the residents got close to each other,[Resident #72] punched [Resident #188] in his face with his right hand ..., Subsequently [Resident #188] fell to the floor... no injuries were noted ..."

Resident Background Information

A. Resident #72 was admitted to the facility on 10/25/18 with the following diagnoses: Non-Alzheimer's Dementia, Ventricular Tachycardia, Chronic Kidney Disease, Depression, and Generalized Muscle Weakness.

A review of the Quarterly Minimum Data Set (MDS) for Resident #72 dated 01/29/22 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating that the resident had severely impaired cognition.

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F 689	Continued From page 224 In Section E (Behavior), Wandering - Presence and Frequency. For the question, "Has the resident wandered. Staff answered, "Behavior of this type occurred 4 to 6 days, but less than daily." B. Resident #188 was admitted to the facility on 01/21/22 with the following diagnoses: Non-Alzheimer's Dementia, Altered Mental Status, Visual Hallucinations, Restlessness and Agitation. A review of the Quarterly Minimum Data Set (MDS) for Resident #188 dated 03/03/22 revealed that facility staff coded a Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating that the resident had severely impaired cognition and wandering that occurred daily. During a tour conducted on 04/11/22 at approximately 9:52 AM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, "... Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #430 [Resident #72] Common behavioral traits, wondering, elopement, med., test refusal... Resident-to-resident altercation #1 02/24/22 [Physician's Progress Note]: "Patient seen because of altercation with another resident. Patient not injured. He is confused and he was separated from the other resident. He needs redirection as the other resident is in a room he used to occupy..."	F 689		8/24/22

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F 689	Continued From page 225 Resident-to-resident altercation #2 03/30/22 at 6:13 PM [Situational, Background, Assessment and Request (SBAR) Communication Tool]:" ... Resident #72 then punched Resident #188. 2. Date problem or symptom started: 03/30/2022 ...Psych consult and initiate behavior monitoring ... Additional Comments. [Resident #72] was walking in the hall and [Resident #188] was walking in the hall as well. When the two of them were close, [Resident #72] then punched Resident #188 in his face with his right hand, to the left side of face. Subsequently, [Resident #188] fell to the floor as a result of the punch. The charge nurse saw the incident and then went to separate the residents immediately. [Resident #72] has been placed on 1 on 1 monitoring at this time. The mobile crisis center was updated and will be out to evaluate the resident ...MD aware... Resident's care plan has been updated to reflect the incident. RP ...made aware of the incident as well." 03/03/22 to 03/31/22 [Daily Behavior Documentation] showed that facility staff documented, "Resident exhibits the following: Going through other people. Elopement attempts. Wandering... Behaviors are constant. Behavior problems led to issues with care" 16 times in Resident #72's medical record. 03/30/22 [Physician's Order]: "Psych (Psychiatric) consult secondary to resident-to-resident altercation." 03/30/22 [Physician's Order]: "Provide resident with 1 on 1 sitter until cleared by psych" Prior to 03/30/22, there was no evidence of an	F 689		8/24/22

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active care plan to address Resident #72's physically aggressive behavior.

The evidence showed that the facility's staff failed to revise Resident #72's plan of care to address his aggressive behaviors resulting in another altercation with Resident #188 resulting in minor injury.

During a face-to-face interview 04/14/22 at approximately 3:30 PM, Employee #7 acknowledged the finding and stated that Resident #72 was no longer a wanderer.

5. Facility staff failed to provide adequate supervision of Resident #151 to protect and prevent two residents (Residents' #71 and #67) from incidences of aggressive behavior (resident-to-resident altercations).

Review of the FRI dated 12/09/21 documented, "... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Review of the FRI dated 01/02/22 documented, " ...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby..."

Resident Background Information

A. Resident #151 was admitted to the facility on 10/22/20 with multiple diagnoses that included: Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia.

Review of Resident #151's medical record revealed:

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12/08/21 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe cognitive impairment.

In Section E (Behavior):

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - "Behavior of this type occurred 1 to 3 days", verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - "Behavior of this type occurred 4 to 6 days", Impact on Resident ... Put the resident at significant risk for physical illness or injury? "yes"; impact on others ... put others at significant risk of physical injury? "yes"; significantly intrude on the privacy or activity of others? "yes"; significantly disrupt care or living environment? "yes"

In Section G (Functional Status): Activities of Daily Living (ADL) Assistance - bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, Resident #151 required "supervision" and "one person physical assist"

Review of the Care Plan revealed:

07/27/21 (Revision date) "As evidenced by a positive PASARR (Preadmission Screening and Resident Review) Level I screen and Level II evaluation, it was determined that the resident

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needs Specialized Services while in the Nursing Facility. Related to: schizophrenia ...Inform the MD (medical doctor) if the Individual has a serious health decline and services previously agreed to may need to be modified or deleted. Inform the MD of any significant changes may require additional evaluation to add, modify or remove services ..."

07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..."

10/18/21 (Revision date) "[Resident #151] has problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with taking medications, non compliant with vital signs, non compliant with shaving and showers. Non compliant with Wader guard placement kicking and hitting ..."

10/20/21 (Revision date) "[Resident #151] has impaired cognitive function or impaired thought processes r/t (related to) Dementia..."

10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..."

10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to

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stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..."

B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension.

Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21 where facility staff coded a BIMS summary score of "09", indicating moderate cognitive impairment, no potential indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions.

C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance.

Review of Resident #67's medical revealed, a Quarterly MDS dated 11/06/21 where facility staff coded a BIMS summary score of "14", indicating intact cognitive response, no potential indicators of psychosis, no physical or verbal behavioral symptoms, limited to extensive assistance with one person physical assist for ADLs and no limitations in range of motion.

Resident -to-Resident Altercation #1:

12/08/21 at 11:18 AM [Nurses Note] "... At

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0730AM, the [Security Officer's Name] and the [Receptionist's Name] observed resident [#151] assaulting another resident [Resident #71] at the front of the building. The security officer and the receptionist ran to the residents and separated both residents... [Resident #71] was interviewed. He said, 'the man jumped on me in front of the building for no reason. I have never spoken to him. I don't know where this came from today' ... asked [Resident #151] why he assaulted [Resident #71]. He said, 'he raped my daughter' ... The MPD (Metropolitan Police Department) was called ... took [Resident #151] because of his aggressive behavior and transported him to [Hospital Name] at 0809 (AM) for evaluation. [Resident #71] was assessed and small scratch mark observed on the back of his left hand..."

Resident-to-Resident Altercation #2:

12/30/21 at 11:30 AM [Nurses Note] "... At 2030 (8:30 PM) on 12/29/2 (12/29/21).., Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby; the receptionist notified the supervisor; the supervisor assessed [Resident #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45 PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site.

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No swelling, discoloration or open area observed during assessment. He denied pain ..."

Review of Resident #151's medical record showed documented aggressive behaviors and a resident- to-resident altercation on 12/08/21. There was no documented evidence that facility staff revised Resident #151's plan of care to protect other residents and then on 12/29/21, Resident #151 attacked another resident at the facility.

During a face-to-face interview conducted on 04/14/22, Employee #7 (Clinical Coordinator) acknowledged the findings and stated that Resident #151 has been on 1:1 since he was admitted back to the facility in 01/2022 and has not had any resident-to-resident altercations.

6. Facility staff failed to properly secure Resident #183's wheelchair during a van transport, resulting in the resident falling.

Review of the FRI dated 10/19/21 documented, "...At 6:33PM on 10/19/21, [Resident #183] ...escort reported to the nurse that when resident was on the van going to this appointment resident slipped under his [seat] belt slit out of his wheel chair when the driver held the brake..."

Resident #183 was admitted to the facility on 03/20/14 with multiple diagnoses including, Acquired Absence of Left Leg Below Knee, Diabetes Mellitus Type 2 and End Stage Renal Disease.

Review of Resident #183's medical record revealed the following:

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A Significant Change MDS dated 10/01/21, showed that facility staff coded the following:

In Section C (Cognitive Patterns), a BIMS summary score of "15", that indicated intact cognition.

In Section G (Functional Status), extensive assistance requiring one-person physical assist with ADLs, uses a wheelchair for mobility device and had no limitations in range motion.

10/14/21 at 2:26 PM [Nurses Note] "Resident was on LOA (leave of absence) for appointment. While in the van his wheelchair tilted backward, and he slipped out of his chair. He denied pain as well as not hurting. He was assisted back to a sitting position and the van proceeded to his appointment. [Resident #183] returned to the facility after the appointment and the incident reported to his unit. Head to toe assessment done with range of motion to extremities with equal strength. He remains alert and oriented X3 with bilateral ling (sp) fields clear. No evidence of shortness of breath noted at this time. ... no evidence of redness nor bruising noted ...Resident is wheelchair bound with a left BKA [below knee amputation]. RP (Resident Representative) and MD made aware."

10/14/21 at 3:42 PM [Care Plan Note] "...Resident's wheelchair should be strapped to the bus at all times when ridding (sp) on the bus for safety reasons."

10/14/21 (Initiation date) [Care Plan focus area] "[Resident #183] is at risk for falls r/t (related to) gait/balance problems. Actual fall on 10/14/21 ...In service the van driver to make sure resident

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is properly strapped on the van before driving off. Alter/remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to cause."

10/21/21 [Physician's Order] "Yellow star fall program..."

During a face-to-face interview conducted on 04/07/22 at 3:05 PM, Resident #183 stated, "Oh I remember the time I fell backward on the bus and bumped my head a little. I didn't have the tilts on my wheelchair."

During a face-to-face interview conducted on 04/08/22 at approximately 2:00 PM, Employee #34 (Van Driver), he stated, "We were still on the property when it happed ... I secured the straps on each side, there are 4 straps. The wheelchair fell backward, all the straps weren't secured. We (Employee #34 and #35) saw that [Resident #183] wasn't injured and took him to [his scheduled appointment]."

During a face-to-face interview conducted on 04/08/22 at 3:15 PM, Employee #35 (Certified Nurse Aide) stated, "He [Resident #183] flipped back, still in the wheelchair. He fell on his back hard."

The evidence showed that facility staff failed to properly secure Resident #183's wheelchair to the facility van prior to transport.

7. Facility staff failed to provide Resident #409 with adequate supervision, assistance and hip precaution to prevent an avoidable accident after she had left hip surgery.

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Review of an intake form for a complaint received by the State agency on 12/06/21 documented " ...after having hip surgery on 07/08/21, was observed two days later on 07/10/21 with "leg positioned like the letter 'K'..." Resident #409 was sent to the hospital for a dislocated hip and hip surgery.

Resident #409 was admitted to the facility on 07/08/21 with diagnoses that included: Encounter for Orthopedic Aftercare, Presence of Left Artificial Hip Joint, Alzheimer's Disease (Unspecified), Repeated Falls, Muscle Weakness (Generalized), and Other Abnormalities of Gait and Mobility.

Review of Resident #409's medical record revealed the following:

A Quarterly Minimum Data Set (MDS) for Resident #409 dated 07/11/21 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating severe impaired cognition.

In Section G (Functional Status), ADL assistance: for transfers, toilet use, and personal hygiene, the resident was totally dependent and required two or more person's physical assistance from two or more staff. For bed mobility, the resident required limited physical assistance from one staff member. For dressing, the resident required extensive physical assistance from one staff member.

In Section H (Bowel and Bladder) - "Always

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incontinent" for bladder and bowel

In Section J (Health Conditions), "Yes" to: resident have a fall any time in the last month prior to admission /entry or reentry; resident have fracture related to a fall in the last 6 months prior to admission /entry or reentry; resident have major surgery during the 100 days prior to admission; resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay.

In Section O (Special Treatments, Procedures, and Programs), start date for Occupational and Physical Therapy "07/09/2021."

07/08/21 at 12:10 PM [Hospital Discharge Summary] "...Hospital Course Patient presented with left hip fracture; status post Arthroplasty (hip replacement). With no postoperative complications ...Discharge Procedure Orders ...Weight Bearing as Tolerated (WBAT); Laterally; Left ...Restrictions as follows: Posterior hip precautions..."

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT. Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach ..."

07/08/21 (3:00 PM-11:00 PM) [CNA Documentation], facility staff documented that Resident #409 was given a bath, assisted with bed mobility and provided incontinent care for bowel and bladder.

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F 689	Continued From page 236 07/09/21 [Physician's Order] "Left hip: monitor left hip for inflammation, pain, and drainage." 07/09/21 at 2:18 PM [Physical Therapy Evaluation and Plan of Treatment Note] "...referred to skilled therapy after having a L (left)) hip hemiarthroplasty that resulted from a fall... Precautions ... (no flexion past 90 degrees, abduction past midline, or internal rotation, WBAT..." 07/09/21 (7:00 AM-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing, assistance with bed mobility, and provided incontinent care for bowel and bladder. 07/09/21 (3:00 PM - 11:00 PM) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed mobility, and provided incontinent care for bowel and bladder. 07/09/21 (11:00 PM-7:00 AM)) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed mobility, and provided incontinent care for bowel and bladder. 07/10/21 [Physician's Order] "Place a pillow between lower extremities after care, turn and reposition when resident is in bed." 07/10/21 [Physician's Order] "Wedge resident appropriately after care, turn and reposition when [the] resident is in bed."	F 689		8/25/22

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07/10/21 (7:00 AM-3:00 PM) [Treatment Administration Record (TAR)], showed that facility staff documented that they placed a pillow between Resident #409's lower extremities after care, and wedged resident appropriately turning and repositioning when the resident was in bed.

07/10/21 (7:00-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing and bed mobility.

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain..."

07/10/21 at 5:40 PM [SBAR] "...Resident transfer to [Hospital Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She [Representative] requested her mom to be transfer[ed] to the Hospital..."

07/10/21 at 6:20 PM [Nurses Note] "...Family was at bedside visiting today from 11:45 AM Resident was seen by the medical director at 12:30 PM, ... At about 4 PM daughter requested that she (Resident #409) needed an X-ray to be done because she want[ed] to make sure her mothers' leg was not dislocated. Writer explains[ed] to the daughter that [the] resident has been seen by the

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doctor in her present (sp) just a few hours ago. If there was any concern note[d] the doctor would have order[ed] an X-ray. She insisted that she want[ed] her mom to be sent to the hospital immediately because she need[ed] an X-ray to be done and read right [away]. Writer told her that an X-ray can be gotten from the doctor, but it will take b/n (between) 2-4 hours for the X-ray to be done ...[Physician's Name] was notified and the doctor said an X-ray will take about 4-6 hours to be done so the resident should be transfer[red] to the hospital via non-emergency transport for further evaluation per family request ...Resident was taken out from the facility at 5:50 [PM] to [Hospital Name]."

07/12/21 at 6:34 PM [Hospital Discharge Summary] "The patient presents from [Name of Facility], where she has been staying for the past few days ... Her daughter and son-in-law went to visit her ... looked under her covers, and found that her left leg was significantly inwardly rotated. They were concerned something is going wrong with the surgery at the left hip, and they requested transportation to the hospital .... ED (Emergency Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced [explain what this means] ...tolerated the procedure well ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..."

A review of the Resident #409's medical record lacked documented evidence that the facility staff that cared for Resident #409 from 07/08/21 to 07/10/21, provided her with adequate supervision, assistance and hip precautions to ensure that Resident #490's hip was not dislocated.

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During a telephone interview conducted on 04/14/22, at approximately 12:30 PM, Resident #409's daughter/representative stated, "On 07/10/21, I noticed that my mother looked out of it and flinched when I pulled back the cover to see what was wrong. I didn't see the knee immobilizer on her leg. Her leg was positioned like the letter 'K'. I spoke with the unit manager and told her I wanted to see the doctor. They finally brought in the doctor, who said he wasn't my mother's primary doctor, and he ordered oxycodone for pain. I insisted that my mother get an X-ray for her hip. I was told the X-ray would take a long time (4-6 hours), so I asked the nurse to call 911. She told me she did not have a doctor's order, and I can call 911, so I did. 911 showed up and said it wasn't a medical emergency, so they [911] called a non-emergency vehicle, and my mother was transported to [Hospital Name]."

During a face-to-face interview on 04/19/22, at approximately 3:30 PM, Employee #4 (Educator) stated, "I told the daughter how long it would take (x-ray). She insisted we call 911 to have [Resident #409's hip X-rayed and evaluated at the hospital. Per the daughter's request, with the doctor's permission, a non-emergency ambulance was called. The resident [was transferred out to [Hospital Name]. I did an SBAR of the incident."

During a face-to-face interview on 04/19/22 at approximately 4:00 PM, Employee #8 (2nd Floor Unit Manager) stated that training for residents with hip precautions usually occurs with physical therapy or by the unit managers when the resident is admitted. For Resident #409, Employee #8 stated, "I did the impromptu training

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F 689	Continued From page 240 in the resident's room. I trained the 2-3 CNAs and two (2) nurses who worked the day and evening shifts on this unit. I reviewed how to put the pillow/wedge between the resident's legs, how to put the hip immobilizer on the resident, and how to roll the resident on her side to prevent her from crossing midline. I reminded staff to keep the bed in the lowest position and keep the call light near the resident." Employee #8 was not able to provide a copy of the "impromptu training" sign in sheet or the handouts that he said were provided to the staff.	F 689		8/24/22
F 695 SS=H	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and family interviews, for two (2) of two (2) sampled residents with laryngectomies, the facility's staff failed to: 1. ensure Resident #3's airway (stoma) was not occluded by a medical device Heat Moisture Exchanger (HME) subsequently, the resident to be transferred to the Emergency Room (ER) for dislodgment, 2. keep a supply of respiratory medical equipment in the facility that was necessary to care for and treat Resident #3's laryngectomy and stoma, resulting in the resident being transferred to the ER for a	F 695	F695 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #3 was discharge from the facility 3/29/2022. Resident #304 was assessed from head to toe on 4/26/2022,by Unit Manager. Resident did not suffer any negative outcomes. MD/RP notified on 4/26/22. Care plan to include goals and approaches will be completed by 8/24/22	

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F 695	Continued From page 241 replacement 3. obtain/provide Resident #3 with HMEs, 4. change and clean respiratory equipment in accordance with the physician's orders for Resident #304, and 4. obtain an order for the use of a "button" (HME) for Resident #304 with a Tracheostomy. These failures resulted in actual harm for Resident #3, example #1. The findings include: 1. The facility's staff failed to ensure Resident #3's airway (stoma) was not occluded by a medical device HME subsequently, causing the resident to be transferred to the emergency room (ER) for dislodgment. According to Johns Hopkins Medicine (https://www.hopkinsmedicine.org/tracheostomy/resources/glossary.html#Tracheotomy) a HME is a humidifying filter that fits onto the end of the trach tube and comes in several shapes and sizes. It is also known by several other terms including Thermal Humidifying Filters, Swedish nose, Artificial nose, Filter, Thermovent T. Resident #3 was admitted to the facility on 12/01/2021 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of an Admission Minimum Data Set (MDS) assessment dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank, indicating the resident had not been assessed. Additionally, the resident was coded for receiving Tracheostomy care and	F 695	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Residents with respiratory problems that are using respiratory equipment to aid in respiration, have the potential to be affected. Respiratory therapist /Designee will assess all the residents who are using respiratory equipment to aide in respiration during their shift to ensure the residents are in no respiratory distress. Any issues found will be corrected by 8/24/22	8/24//22

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F 695	Continued From page 242 speech therapy services. A continued review showed that Resident #3 was not coded for receiving respiratory therapy services. Review of the resident's medical record revealed the following: -12/01/21 at 19:54 [admission nursing progress note]- Resident underwent awake tracheostomy with direct laryngoscopy and biopsy on 10/27/27 ...upon assessment, resident alert and oriented to person and place. ...Resident has a lary tube with cap [HME] in place ... -12/01/21 at 20:29 [physician assistant physician progress note]- Pt. (patient) seen at bedside appears alert and stable ...Pt. also has tracheostomy and doing well ...vitals: 126/81 (blood pressure), 86 (pulse, 18 (respiration), 97.6 (temperature), 95% RA (oxygen saturation rate on room air) ... -12/02/21 [physician order]- Change HME daily day shift. -12/02/21 at 13:15 [respiratory therapy assessment]- Type- initial assessment, Resident was alert and oriented with lary tube and holder in place with an HME. Lary tube cleaned, tube holder changed. HME changed. Pre-treatment assessment respiratory rate 18, SPO2 98% [on] room air, lung sounds clear ... Post-treatment assessment respiratory rate 18, SPO2 (peripheral capillary oxygen saturation) 99% on room air, lung sounds clear... -12/03/21 [physician order] - transfer resident to the nearest ER (emergency room) for further evaluation related to stuck HME in stoma.	F 695	F 695 MEASURES TO PREVENT RECURRENCE: In- service will be provided by Staff Educator to all licensed nursing staff to ensure that residents on respiratory equipment are assessed by the licensed nurse every shift ,make sure the stoma is not occluded, that the respiratory equipment is clean, and that respiratory supplies are always at the bed side and in central supply storage room. In addition, respiratory medical equipment will be cleaned by Respiratory therapist /Designee on a weekly basis. This will be completed by 8/24/22. Repeat in-service provided as needed. Education will be provided to licensed nursing staff by staff educator on how to carry out CRP on a resident with HME, or Lary tube completed by 8/24/2022. Charge nurses and Supervisors will ensure weekly that residents with respiratory issues are assessed , that residents are in no respiratory distress, that care plan goals are in place to reflect their diagnosis and that interventions are implemented as indicated . Any issues found will be addressed by 8/24/22	8/24/22

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F 695	Continued From page 243 -12/03/21 at 14:42 [nursing progress note] - The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma (airway) was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME initially stuck down in stoma (airway) and the resident coughed it up ...Resident's daughter ...called and spoke with Respiratory Therapist ...wanted to find out if resident was alive, in distress or pain and asked ...how she determine that since resident is non-verbal ... 911 called at 1345 and they arrived at 1400 ... v/s (vital signs): 121/80 (blood pressure), 63 (pulse), 18 (respirations), 97.8 (temperature), O2 Sat (saturation) 99% RA (room air). -12/04/21 [hospital discharge summary]- Diagnosis-tracheostomy malfunction. Diagnostic radiology XR (x-ray) neck soft tissue, XR chest PA (posterior-anterior) and LAT (lateral) 2 view. Call for follow-up appointment with physician within 2 to 4 days [provided education tool] for "How to Clean a Tracheostomy Tube, Adult." -12/04/21 at 07:54 [nursing progress note] -	F 695	Respiratory therapist will assess residents with respiratory diagnosis during their shift to ensure that they have adequate respiratory supply. Will also ensure daily that the respiratory equipment is clean. Also ensure documented evidence of assessment. Any issues found will be corrected by 8/24/22 Unit Mangers will ensure that all residents with respiratory diagnosis are in no form of respiratory distress while conducting rounds during their shifts. Any issues found will be reported and corrected by 8/24/22 Charge Nurses will check on residents with respiratory diagnosis on their units during their shift to ensure they are in no respiratory distress. Any issues found will be addressed by 8/24/22 Unit Managers/ supervisors will ensure that the nurses take orders for HME and implement them as indicated. Supervisors will be notified through supervisor report and validation meeting. Any issues found will be corrected by 8/24/22 Coaching and counselling will be provided by Staff Educator / designee to charge nurses who are not implementing physician orders as indicated by 8/24/22 Respiratory therapist/ central supply coordinator will ensure respiratory equipment are available through weekly audits. Any issues found will be corrected by 8/24/22	8/24/22

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F 695	Continued From page 244 Resident came back from the hospital ...on arrival 129/89 (blood pressure), 18 (respiratory rate) 98% (oxygen saturation rate) on room air. -12/04/21 [physician order] - Do not occlude stoma in neck. The [patient] is an obligate neck breather. -12/06/21 at 16:13 [physician assistant progress note] - Re-admission follow-up, pt (patient) was hospitalized for tracheostomy malfunction. Pt. seen at the bedside appears alert and stable ...vitals: 130/67 (blood pressure), 71 (pulse), 17 (respirations), 97% RA (oxygen saturation rate on room air) ...resp (respiration): lung CTA (Clear to auscultate), BL (bilaterally). However, further review of progress notes lacked documented evidence that Employee #31 (Respiratory Therapist) assessed or provided care for Resident #3 from 12/03/21 to 12/06/21 (post being sent to the emergency room). Review of the December 2021 Treatment Administration Record showed the following: Change HME daily day shift (start date 12/03/21). The facility's nurse initialed on 12/03/21 indicating that she changed Resident #3's HME on dayshift Review of the comprehensive care plan with an initial date of 12/04/21 showed the following: Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer. Goal- [resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed...	F 695	F 695 MEASURES TO PREVENT RECURRENCE CONT. Respiratory therapist will also ensure that there is documented evidence of intervention to address residents with respiratory needs weekly. Findings will be corrected by 8/24/22. Respiratory therapist must provide training to all licensed nurses on what an HME is and how to care for residents with an HME .Documented evidence on education provided must be kept handy. Unit managers will ensure that nurses are following the physicians order as they provide care to residents with respiratory needs. Findings will be corrected by 8/24/22 Education will be provided to licensed staff on the importance of signing the treatment record only when care is provided. Training will also be conducted by respiratory therapist to all licensed nurses on how to use other respiratory equipment such as CPAP	8/24/22

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F 695	Continued From page 245 Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22. Review of a complaint received by the DC Department of Health on 01/26/22 from alleged that Resident #3 was rushed to the ER on 12/03/21, because there was an HME put into his (Resident #3) neck stoma (airway)." Resident #3 was unable to be interviewed at the time of the survey because he was discharged to the hospital on 03/29/2022. During a telephone interview on 04/12/22 at 11:35 AM, the resident's responsible party (granddaughter) stated that the clinical coordinator and the respiratory therapist called her informing her that the HME was stuck in her grandfather's stoma. When asked if they informed her what happened, she said, "No, neither one of them could explain, but [name of clinical coordinator] said sometimes there are things that happened that we can't explain." During a face-to-face interview on 04/12/22 at approximately 5:00 PM, Employee #32 (LPN) stated, I cleaned something in his neck two times a shift. Respiratory sees him (Resident #3) all the time. I had training from respiratory, but I don't remember when." The employee also stated, "I don't remember the resident (Resident #3) using a HME." During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator)	F 695	MEASURES TO PREVENT RECURRENCE CONTINUE Unit manager will ensure that resident # 304 has all supplies needed to take care of his respiratory need's weekly. Also, to ensure that the licensed nurse get a physician order for HME for tracheostomy status for the resident. Findings will be addressed by 8/24/22 Unit managers will ensure that a person-centered approach is created to care for residents with laryngectomy or other respiratory needs weekly. Findings will be corrected by 8/24/22. In service will be provided by Respiratory therapist to all licensed nurses on how to provide care to residents with respiratory diagnosis Respiratory therapist must ensure weekly that the know the size of respiratory equipment and ensure the facility supplies it to the resident . Findings will be corrected by 8/24/22. Unit managers/ supervisors will validate that the resident's respiratory equipment is cleaned by the charge nurses/ respiratory therapist during their shift. Findings will be addressed by 8/24/22 Unit managers will ensure that the charge nurses are putting in correct documentation in the treatment records for care provided to the residents. Findings will be corrected immediately. MDS coordinator must ensure that residents with respiratory diagnosis are coded accurately. Unit managers will ensure residents on tracheostomy are suctioned by the respiratory therapist and licensed nurses during their shift. Findings will be corrected by 8/24/22. Respiratory therapist are in house daily.	8/24/22

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reported that when the respiratory therapist informed him that an HME was stuck in the resident's stoma (airway), he had Resident #3 transferred to the emergency room for evaluation. The employee then shared that Resident #3 was not in any distress when the HME was lodged in his stoma (airway). When asked if an investigation was conducted to determine how the incident of the HME being lodged in Resident #3's stoma (airway) happened, Employee #7 stated, "No." The employee also said the respiratory therapist was responsible for changing the resident's HME.

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that she informed the staff that Resident #3's HME was "stuck in his stoma (airway). I'm not sure how the HME got stuck in his stoma. If he (Resident #3) did not get the HME out of his stoma it would have been detrimental." The employee stated that she worked three to four days a week, and on the days, she was not in the facility nursing staff was responsible for cleaning Resident #3's lary-tube and changing the HME. Also, Employee #31 said that she provided nursing staff education on how to care for Resident #3's lary-tube and HME and documented the training on a clipboard in her office. The employee also said she required nursing staff to do a return demonstration to ensure competency.

During a face-to-face interview on 04/14/22 at approximately 3:00 PM, Employee #33 (RN) stated that respiratory therapy provided her with training on tracheostomy care, but they did not provide education on laryngectomy's, lary-tubes, or HMEs. The employee said that although she

DON/Designee will conduct house wide audit to ensure that residents with respiratory problems are in no respiratory distress, that the residents with respiratory problems have all needed supplies, that the respiratory equipment and clean and that there is documentation in place that care was provided. This audit will be carried out weekly x 4 then monthly x3. Findings will be corrected and reported to QAPI COMMITTEE.

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regularly worked on the floor where Resident #3 resided, she could not remember working with him.

A review of in-service training documents lacked documented evidence that staff was provided education on the lary-tubes or HMEs.

During a face-to-face interview on 04/14/22 at approximately 3:30 PM, Employee #4 (Educator) stated that the respiratory therapist was responsible for providing staff education on the lary tube and HME. The employee said that the respiratory therapist was to provide her with written documentation of education provided to staff. However, she said, "I don't have any records of education provided by the respiratory therapist."

There was no evidence that facility staff developed a person-centered approach to care for and provide necessary services to Resident #3 who had a laryngectomy. Subsequently, Resident #3's airway (stoma) was occluded by a medical device HME, causing him to be transferred to the ER for dislodgment of the device.

2. The facility failed to keep a supply of respiratory medical equipment in the facility that was necessary to care for and treat Resident #3's laryngectomy (lary-tube) and stoma (airway). Subsequently, the resident had to be transferred to the ER for a replacement.

According to the University of Arkansas for Medical Science, a lary tube is a flexible silicone tube designed to maintain the stoma right after

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the laryngectomy surgery. A lary tube is used to maintain the airway and can be following a laryngectomy. (https://patientslearn.uams.edu/wp-content/uploads/sites/95/2018/03/Lary_Tube_Care.pdf)

Review of Employee #31's (Respiratory Therapist) signed and dated 06/03/19 job description, showed that she was responsible for providing necessary material and equipment for resident (sp) to perform required therapy.

Review of an Admission MDS assessment dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank, indicating the resident was not assessed. Additionally, the resident was coded for receiving Tracheostomy care and speech therapy services.

Review of the resident's medical record revealed a physician's order dated 12/02/21that stated, "Cleanse Lari-tube daily on day shift."

Further review of Resident #3's medical record revealed the following nursing progress notes:

-01/07/22 at 4:51 PM: "It was observed today that resident Laryn [lary] tube is out. He was assessed by the respiratory therapist and recommended to send resident out to the ER for laryn [lary] tube replacement. 911 arrived ...left at 4:40 PM. "

-01/07/22 at 6:10 PM: "[MD's Name] called from [Name of Hospital] need to know the size laryngectomy tube. RT (respiratory therapy) note said size was gathered at admission."

-01/08/22 at 6:32 AM: "Resident returned from [Name of Hospital] at 2:30 AM in stable condition

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F 695	Continued From page 249 ... O2 SAT (oxygen saturation) 95% RA (room air)."; and -01/08/22 at 4:02 PM: "Resident alert and oriented...Resident observed with difficult breathing with the new lary tube placed from hospital 1/7/22. Resident's family took him to [Name of Hospital] for follow-up and possible change of lary tube...resident ... O2 sat (oxygen saturation) 98." Review of the comprehensive care plan with an initial date of 12/04/21 and revision date of 1/7/22 showed the following: Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer, 01/07/22 sent out for laryn (sp) tube placement, taken to ER for laryn (sp) tube replacement. Goal- [resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed... Review of a respiratory therapy assessment/infection screener progress note lacked documented evidence the respiratory therapist assessed or provided care for Resident #3 from 01/05/22 to 01/12/22. Review of complaint #DC00010525 showed the complainant alleged that Resident #3 was sent to the ER on 01/07/22 for a lary tube replacement due to facility throwing out the one (lary-tube) he had. During a telephone interview on 04/12/22 at 11:35 AM, the resident's granddaughter stated that the	F 695		8/24/22

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facility made her aware of the lary-tube missing. She stated, "I told them that my grandfather's lary tube was missing when I visited him 5 days prior. I asked them why it took them so long to get his lary-tube replaced."

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that when the resident's lary tube was misplaced (01/07/22) she had the resident sent out the ER for replacement. The employee then reported that while Resident #3 was in the emergency room the emergency room staff called her to inquire about the size of the resident's lary-tube, but she could not give the physician the size because she did not know the size of the resident's lary- tube. When asked if it was her responsibility to order respiratory supplies, Employee #31 said, "Yes" but she could not order Resident #3's lary-tube because she "did not know the size." When asked if she made the resident's physician or medical director aware, the employee stated, "No, I don't talk the doctors. I made [Administrator's name] and [Clinical Director's name] aware several times.

Through interview with Employee #31 there was no evidence that facility staff knew the size of Resident #3's Lary Tube to order replacements, therefore, none were available in the facility for use. Subsequently, Resident #3 was sent to the emergency room for replacement of the lary tube.

3. Facility staff failed to obtain/provide Resident #3 with HMEs that were necessary to help reduce mucus production and coughing by humidifying and filtering the air breathed through his stoma from 01/08/22 to 03/02/22.

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F 695	Continued From page 251 According to Oxford University Hospital, it is important to keep your mucus thin so that it is easy to cough up [mucous]. You should always wear a stoma protector such as a ...Heat Moisture Exchange (HME: baseplate and cassette). These are available on prescription and will moisten mucous ... https://www.ouh.nhs.uk/patient-guide/leaflets/files/11587Pstoma.pdf Review of complaint #DC00010525 revealed allegations that the facility did not have lary-tubes and HMEs for Resident #3. Review of Resident #3's medical record showed the following Physician's orders: 12/02/21 [Physician's Order] "Change HME daily Day shift." 12/02/21 [Physician's Order] "Change Lari-Tube daily Day shift." The medical record also contained the following nursing notes: 01/07/22 at 4:51 PM [nursing progress note]- It was observed today that resident larynx tube is out. He was assessed by the respiratory therapist and recommended to send resident out to the ER for larynx tube replacement. 911 arrived ...left at 4:40 PM. However, review of respiratory therapy assessment / infection screener progress notes lacked documented evidence the respiratory therapist assessed or provided care for Resident #3 from 01/05/22 to 01/12/2022.	F 695		8/24/22

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-01/07/22 at 6:10 PM [nursing progress note] - [MD's Name] called from HUH (Howard University Hospital) need to know the size laryngectomy tube. RT (respiratory therapy) note said size was gathered at admission.

-01/08/22 at 6:32 AM [nursing progress note] - Resident returned from HUH at 2:30 AM in stable condition ...vs (vital signs): 144/75 (blood pressure), 18 (respiration), 70 (pulse), 96.8 (temperature), O2 SAT (oxygen saturation) 95% RA (room air).

-01/08/22 at 4:02 PM [nursing progress note] - Resident alert and oriented. Resident tolerated -feeding and all medications. Resident observed with difficult breathing with the new lary tube placed from hospital 1/7/21. Resident's family took him to [Name of Hospital] for follow-up and possible change of lary [laryngectomy] tube ...resident ...O2 sat (oxygen saturation) 98.

Review of Treatment Administration Records from 01/08/22 to 03/02/22 showed that the facility's nurses initialed they changed Resident #3's HME daily on dayshift. However, it should be noted that per the respiratory therapist (Employee #31) the HME could not be changed from 01/08/22 to 03/02/22 because the facility did not have HMEs compatible to connect with Resident #3's lary-tube.

Review of the comprehensive care plan with an initial date of 12/04/21 showed the following:
Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer, 01/07/22 sent out for laryn (sp) tube placement, taken to ER for laryn (sp) tube replacement.
Goal- [resident's name] will have no abnormal

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drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed...

Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22.

Review of the of an invoice dated 03/02/22 showed the facility ordered one box of 30 cassette HMEs and 1 laryngectomy (Lary) tube. Further review of the invoice showed handwritten entry "received [on] 03/03/22".

Review of emails from Resident #3's responsible party to Employee #11 (Social Worker) showed the following:

02/22/22 at 9:30 AM -"On February 7th and February 8th, I emailed [Employee #31's name-respiratory therapist] in reference to Resident #3's name lary-tubes and HME's being ordered. In prior conversation she (Employee #31) stated that she needed to know the size of tube so that she (Employee #31) could order his (Resident #3) supplies. I gave her the information on the 7th (02/07/22). Checked back with her the following Monday 02/14/22) and she stated she order the belonging (Lary-tubes and HMEs) ...She (Employee #31) has the information and the items (lary-tubes and HMEs) need to ordered ASAP."

03/07/22 at 12:54 PM- Has anyone looked into his (Resident #3) lary tubes and HMEs being

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ordered. I gave the needed information, and he still hasn't received those supplies that [Employee #31's name- respiratory therapist] ordered on February 7th of 2022. She stated that she would get back with me and never did. Theses supplies are important necessities to his current state he is in."

03/25/22 at 12:47 PM -It was told to me that the HME's and lary-tubes were ordered for [Resident #3's name] back in February. Medicaid is requesting the invoices for said orders ...Can you send me any and all documentation in reference to these invoices?

During a telephone interview on 04/12/22 at 11:35 AM, the resident's emergency contact (granddaughter) stated, "He was without a lari-tube several times and they (lari-tube) had to be replaced by the treatment (chemo infusion center) center. She further stated, "I emailed [Employee #31; respiratory therapist] on 02/07/22 and 02/08/22 size for supplies (lari-tube, collar, and straps) but she never responded. I called her (Employee #31) a week later (02/14/22) and she said [Employee #7-Clinical Coordinator] approved the supplies and she (Employee #31) ordered them."

During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated, "We had a problem with supplies one time, and I told the respiratory therapist (Employee #31) and she ordered them."

During a face-to-face interview on 04/14/22 at approximately 2:00 PM, Employee #11 (Social Worker) stated that Resident #3's granddaughter emailed him on 02/22/22, 03/22, and 03/29/22

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inquiring about order for supplies (HMEs and Lary-tubes).

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that Resident # 3 did not a have HME to connect to his lary-tube from "01/08/22 to until they were ordered and received by the facility [03/03/22]". When asked why it took so long for Resident #3 to get the HME, Employee #31 said "I did not know the size of the resident's lary-tube. And the HMEs we had in house was not compatible with the lary-tube his family provided on 01/08/22." The employee then said she reached out to the granddaughter on 01/12/22 or 01/13/22 to get the name of the lary-tube so she could order an HME, but the granddaughter said, "The doctor told me (granddaughter) that the HME is not important", and she did not send me the size of the lary-tube until 02/07/22." Employee #31 said that she did call the resident's physician once to get the size of his lary-tube once, but he did not call her back. However, she made Employee #1 (Administrator) and Employee #7 (Clinical Coordinator) aware multiple times that Resident #3 did not have HMEs.

It should be noted that nursing staff documented in Treatment Administration Records that they changed the resident's HME on the following dates:
01/09/22 to 01/25/22
01/27/22 to 02/02/22,
02/04/22 to 02/08/22,
02/11/22 to 02/14/22,
02/18/22 to 02/22/22
02/24/22 to 03/01/22.

However, it should be noted the invoiced provide

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by the facility with an order date of 03/02/22 showed the facility did not receive HMEs until 03/03/22, at which time they received 30.

During a face-to-face interview on 04/20/22 at approximately 2:00 PM, Employee #44 (Admission Director) stated that newly admitted residents' medical supplies are ordered and in the facility before the resident's admission. When asked if Resident #3's lary-tubes and HME were ordered and in the facility before his admission (12/01/22), she stated, "I don't know because I was not in the facility at that the time he was admitted. It should be noted that the one (1) invoice the facility provided to the surveyor had a date of 03/02/22, which documented that the facility received one (1) lary-tube and 30 HMEs on 03/03/22.

4. Facility staff failed to change and clean respiratory equipment in accordance with the physician's orders and failed to obtain an order for the use of a "button" (HME) for Tracheostomy Status and failed to develop a care plan with goals and approaches to address the use of an HME for Resident #304.

Resident #304 was admitted to the facility on 10/17/2019 with diagnoses that included: Tracheostomy Status, Personal History of Malignant Neoplasm of Larynx, Peripheral Vascular Disease, Muscle Weakness (Generalized), and Other Abnormalities of Gait and Mobility.

A Quarterly Minimum Data Set (MDS) dated 03/28/2022 revealed the resident was coded as follows:

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F 695	Continued From page 257 Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "15," indicating that the resident was cognitively intact. Section G (Functional Status) G0110 Activities of Daily Living (ADL) Assistance: for bed mobility, transfers, and personal hygiene, the resident required extensive physical assistance from one staff member; and for eating the resident required limited physical assistance from one staff member. Section O (Special Treatments, Procedures, and Programs): O0100 Special Treatments. Respiratory Treatments resident receives oxygen therapy, suctioning, and tracheostomy care. The number of days this therapy was administered for at least 15 minutes a day in the last seven days was "0." A review of Resident #304's medical record revealed: 10/17/2019 [Hospital Discharge Summary]: " ...PMH (past medical history) of laryngeal cancer with laryngectomy with permanent tracheostomy (15 years ago) ... Laryngeal Cancer: stable. s/p (status post) laryngectomy with trach (2004). Does not need O2 (oxygen) at baseline but needs humidification of the stoma. SpO2 (oxygen level) goal >90%. SLP (speech-language pathologist) was consulted about a replacement speaking valve. 11/30/2019 [Physician Orders]: " ...Ensure tracheostomy kit is at resident bedside at all times."	F 695		8/24/22

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F 695	Continued From page 258 01/17/2020 [Physician's Order]: "Oxygen at 3L/min continuously via trach mask every shift." 11/30/2020 [Physician's Order]: Change trach set-up weekly every Monday & PRN ... Change O2 tubing and humidifier bottle weekly & PRN one time a day every [Monday] 02/18/2022 [Respiratory Therapy Assessment]: " ... Resident alert and oriented in no distress on trach collar. Humidification set-up changed and dated. Voice prosthesis cleaned. Small tan secretion expectorated." 02/14/2022 [Physician's Order]: ..."Clean concentrator and air compressor filters weekly and PRN as needed.' 04/04/2022 [Physician's Order]: "Check Spo2 every shift to maintain above 92%. Notify MD (medical doctor/RP (representative) if noted below (2% every shift." According to the March 2022 Treatment Administration Record, facility staff were signing in the designated spaces to indicate that they: Changed the O2 tubing and humidifier bottle weekly and PRN one time a day every [Monday] on 3/7/2022, 3/14/2022, 3/21/2022 and 3/28/2022.; and they cleaned [oxygen] concentrator and air compressor filters weekly and PRN as needed on 3/07/2022, 3/14/2022, 3/21/2022 and 3/28/2022. According to the April 2022 Treatment Administration Record, facility staff were signing in the designated spaces to indicate that they:	F 695		8/24/22

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Changed the O2 tubing and humidifier bottle weekly and PRN one time a day every [Monday] on 04/04/2022 and 04/11/2022; and they cleaned [oxygen] concentrator and air compressor filters weekly 04/04/2022 and 04/11/2022.

During a second-floor tour on 04/04/2022 at 12:31 AM, Resident #304 was observed in his room lying on his bed and watching television. He was receiving humidified oxygen via corrugated tubing connected to his trach collar on one end and connected to a humidifier bottle of sterile water that had oxygen filtered into it on the other end. The corrugated tubing had no label to indicate when facility staff last changed it, and the sterile water bottle had a label dated 03/06/2022.

On 04/04/2022 at 3:30 PM, during a face-to-face interview with Employee #2, Director of Nursing (DON), she stated that usually, the nurses and the respiratory therapist are responsible for providing care to the residents, but the facility currently had no respiratory therapist. She reported that the facility had a part-time respiratory therapist (RT) who stopped showing up after the last shift on 3/20/2022, from 7: 00 AM to 4:30 PM. When asked if the nurses were trained to order tracheostomy supplies, suctioning equipment, adjust settings on CPAP (Continuous positive airway pressure), etc. She said, "No, that was done by the respiratory therapist in the past. She reported that she was in the process of contacting an agency RT and should have one confirmed by the end of the day. She also stated that she would check Resident #304 and make sure the resident's tubing and humidification bottle were changed and dated.

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During observation and interview on 04/07/2022 at 4:18 PM, Resident #304 was observed lying in his bed. The resident was wearing a trach collar and was receiving humidified oxygen. The oxygen tubing and the humidified oxygen bottle had labels dated 04/05/2022. When asked who is responsible for suctioning and providing his trach care, the resident stated, " I do not get suctioned. I cough up sputum myself. I do not have a trach; I have a laryngectomy with a valve. I use humidified oxygen to keep my stoma moist and help me breathe. The respiratory therapist used to come in once a week to clean my stoma and change out everything, but I haven't seen the RT in a few weeks."

There was no evidence of a tracheostomy kit at the resident's bedside per the physician's orders and no evidence of the resident's "button" that he uses to breathe outside of the facility.

During a second-floor tour on 04/18/2022 at 9:23 AM, Resident #304 was observed wearing his trach collar and was receiving humidified oxygen. The oxygen tubing and the humidifier bottle had labels from 04/05/2022 on them. The oxygen concentrator was beside the resident's bed. The concentrator and the air filters to the concentrator were dirty.

On 04/18/2022 at 9:30 AM, during a face-to-face interview with Employee #39 (Registered Nurse), she stated that Resident #304 does not have a tracheostomy and does not require suctioning. She added that she had recently provided him with stoma care (cleaned the stoma), but the respiratory therapist changed the trach set-up (trach collar, tubing, and humidification bottles). She also knew nothing about the resident's

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button.

On 4/18/22 at 9:49 AM, Employee #8 (Unit Manager/Registered Nurse), present at the time of the observation, when asked who was responsible for cleaning the concentrator at the resident's bedside, he responded the nurses were responsible. He acknowledged the resident's dirty oxygen concentrator and air filters and said he would clean them.

During a face-to-face interview on 04/18/2022 at 11:30 AM with Employee #42 (Newly hired Respiratory Therapist), he stated he was contract staff for the facility, and he had just started yesterday. He said he was not provided an orientation to the facility and had just met the residents requiring respiratory care. He said he would have to schedule a meeting with the DON to determine what supplies were needed. He explained that the clear button Resident #304 referred to is an HME like a nose; it helps the resident breathe. He noted that Resident #304 could not find his HME and stated he would follow up.

Through observation, review of Resident #304's medical record, review of facility documents, and resident and staff interviews, facility staff documented that they were changing the O2 tubing and humidifier bottle weekly and cleaning the concentrator and air compressor filters weekly, however through observation and staff interview it was noted that it did not occur.

Also, through review of Resident #304's medical record did not show an order for the use of an HME for the resident, and no care plan with goals and approaches to address the use of an HME

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F 695	Continued From page 262 for the resident.	F 695		8/24/22
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 105 sampled residents, facility staff failed to administer pain medication to Resident #118 in accordance with the physician's order; and failed to assess Resident #236's pain before administering Tylenol (pain reliever). The findings include: Review of the facilities policy titled "Pain Management" revised March 2022, showed: " ...The relief of pain in resident becomes a priority. It is also our duty to monitor and assess for signs and symptoms of pain, advocate for pain management and meet our goal of keeping resident as comfortable as possible. ...Meeting resident need for pain management; nursing staff will proceed as follows: -Assess for signs and symptoms of pain which include verbal and nonverbal gestures. - Vital signs if appropriate -note the type of pain -Location of pain -Characteristics of the pain (sharp, stabbing and throbbing etc.)	F 697	F697 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #118 was assessed for pain by Unit Manager, on 4/26/22/ Resident denied pain. Resident suffered no negative outcomes.MD/RP notified on 4/26/22. Resident # 236 was assessed on 4/26/22 for pain by Unit Manager. Resident denies pain. Resident suffered no negative outcomes. MD/RP notified on 4/26/22.	

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(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 697	Continued From page 263 -Rating of Pin numerically on a scale od 0-10 or use of facial expression chart to determine pain severity. -Provide non pharmacologic approach as needed or as requested by resident. -Medicate for pain -Monitor the effectiveness of pain medication through reassessment. -Document nursing assessment, nursing intervention, behavior of resident during pain assessment; and resident response to interventions." 1. Facility staff failed to administer pain medication to Resident #118 in accordance with the physician's order. Resident #118 was admitted to the facility on 01/28/22 with diagnoses that included, Insomnia, Alcohol Dependence, Hypertension, Displaced Intertorchanteric Fracture of Left Femur, Tobacco Use and History of Falling. According to the Quarterly Minimum Data Set Dated 04/11/22, Under Section C0500 BIMS Score showed Resident #118 was coded as a "15" indicating that she was cognitively intact. Under Section E Behavior, the resident was coded as no behaviors exhibited. Under Section J Health Conditions, the resident was coded for Pain and receiving pain medication; Under Section J0600 the resident's pain intensity was 05. According to the physician's orders the resident receives Oxycodone hcl 5mg (medication is used to help relieve moderate to severe pain) 1 tab by mouth every 4 hours as needed for moderate to	F 697	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. ADON. Clinical Care Coordinator, Charge nurses, Supervisors and Unit Managers will conduct house wide audit to ensure that the nurses are administering pain medication according to the physician's order and that residents are assessed for pain prior to and after administering pain medications. Any issues found will be corrected by 8/21/22	8/24/22

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F 697	Continued From page 264 serve pain (4-10). Review of the February 2022 Medication Administration Record showed Resident #118's pain level when he was administered the medication on the following dates: 02/04/22 at 14:30- Pain Level = 1; 02/09/22 at 14:48 - Pain Level =1; 02/14/22 at 04:39 - Pain Level =2; 02/16/22 at 09:00 - Pain Level=1; 02/18/22 at 10:30 - Pain Level =3; 02/19/22 at 11:30 - Pain Level =3; 02/26/22 at 08:58 - Pain Level =0; 02/27/22 at 08:01 - Pain Level =0; Review of the March 2022 Medication Administration Record showed Resident #118's pain level when he was administered the medication on the following dates: 03/01/22 at 08:05- Pain Level = 2; 03/03/22 at 08:07 - Pain Level =2; 03/04/22 at 08:06 - Pain Level =2; 03/12/22 at 10:59 - Pain Level=3; 03/26/22 at 00:06 - Pain Level =0; Review of the April 2022 Medication Administration Record showed Resident #118's pain level when he was administered the medication on the following dates: 04/05/22 at 07:15- Pain Level = 0; There was no evidence that on the aforementioned dates, facility staff administered Oxycodone hcl 5mg to Resident #118 within the perimeters as directed by the physician.	F 697	MEASURES TO PREVENT RECURRENCE In- service will be provided by Staff Development team / Designee to all licensed nursing staff to ensure that they assess residents for pain before and after administration of pain medication and that the medication is administered according to physician's order and outcome of medication documented by 8/24/2022. Unit Mangers will conduct rounds on their units during their shift to ensure that the nurses are assessing residents for pain, pre and post administration of pain medication and that pain medications are administered according to the physician order. Any issues found will be addressed by 8/24/22. Supervisors will audit weekly to ensure that nurses are assessing residents before administering pain medication and that the medication is administered per physician's order. Any issues found will be corrected by 8/24/22.	8/24/22

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F 697	Continued From page 265 During a face-to-face interview with Employee #7 on 04/11/22 at approximately 1:30 PM, He stated, " I believe the nurses were documenting the effectiveness of the pain medication and forgot to document the initial pain level." 2. Facility staff failed to assess Resident # 236's pain before administering Tylenol. Resident #236 was admitted to the facility on 10/01/21, with the following diagnoses: Unspecified Cirrhosis of Liver, Fusion of Spine, Cervical Region, Other Chronic Pain, and Other Displaced Fracture of Sixth Cervical Vertebra, and Sequela. Review of the Quarterly Minimum Data Set (MDS) dated 03/16/22 revealed: In section C (Cognitive Patterns) Brief Interview for Mental Status Summary Score of "15" was coded by facility staff and indicates intact cognition. In section J (Health Conditions): J0100 Pain Management "At any time in the last 5 days has the resident?" "Received scheduled pain medication regimen? Facility staff coded "0" No" "Received PRN pain medication or was offered and declined?" Facility staff coded "0" No." J0200 "Should a pain assessment interview be conducted?" Facility staff coded "1" Yes. J0300 "Pain Presence ...Have you had pain or hurting at anytime in the last 5 days?" Facility staff coded "0" No.	F 697	F 697: MONITORING CORRECTIVE ACTIONS: DON/ Designee will conduct house wide audit to ensure that nurses are assessing residents before and after administering pain medication and that the medications are administered according to the physician's order. This audit will be conducted weekly x4, then monthly x3, findings will be addressed immediately and reported to QAPI Committee.	8/24/22

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F 697	Continued From page 266	F 697		8/24/22

Review of the care plan with a focus area of: "... potential for alteration in comfort/pain related to immobility, neck and bilateral shoulder pain" revised on 10/05/21, "... interventions: "Administer pain medication as per MD (medical doctor) orders and note the effectiveness. Assess effects of pain on patient such as accompanying symptoms, sleep, appetite, physical activity, relationships with others, emotion's ability to concentrate etc. Evaluate for and report pain signs/symptoms i.e. exact location, character, severity, contributing factors ... Evaluate pain characteristics intensity, location, precipitating /relieving factor. Give PRN medications for breakthrough pain as per MD orders and note the effectiveness."

Review of the physician's orders revealed the following:

03/14/22- "Tylenol Tablet 325 mg Give 2 tablets by mouth every 6 hours as needed for mild pain (1-3) ..."

03/14/22- "Pain relief maximum strength patch 4% Lidocaine Apply to left deltoid topically in the morning for pain for 15 days and remove after 12 hours."

During an observation and interview on 03/29/22 at approximately 12:20 PM, Employee #37 (Registered Nurse) was administering medications to Resident #236 when he asked the Employee for something for pain. Employee #37 administered the Acetaminophen but did not assess the resident's pain level (such as mild, moderate, severe). The surveyor asked Employee #37 why she did not assess the residents pain level. The Emplpoyee

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F 697	Continued From page 267 acknpwleded that she did nto assess Resident #236's pain level and stated, "No, I didn't ask."	F 697	F 698	8/24/22
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for five (5) of 105 sampled residents, facility staff failed to: (1) ensure the dialysis communication form (used to reflect ongoing collaboration between the facility and dialysis staff contained pertinent information that reflected the resident care) was completed and included in the medical record as part of the record and (2) have an emergency kit (pressure bandage) at bedside of a resident who had an arteriovenous graft dialysis access site. Residents' #61, #95, #181, #182 and #502. The findings include: 1. Facility staff failed to ensure the dialysis communication form used to reflect ongoing collaboration between the facility staff and dialysis staff was included as part of Resident #61's medical record. Resident #61 was admitted to the facility on 11/06/20 with multiple diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Viral Hepatitis C, Anemia,	F 698	CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENTS: Resident #61 was assessed from head to toe on 4/26/22 by Unit Manager. Resident suffered no negative outcomes. MD/RP notified on 4/26/22.Dialysis communication slip will reflect ongoing collaboration between nursing and dialysis staff by 8/24/22 Resident #95 was assessed from head to toe by Unit Manager on 4/26/2022. Resident suffered no negative outcomes. MD/RP notified on 4/26/22. Dialysis Communication slip will be placed in residents' chart immediately but no later than 8/24/22. Resident #181 was assessed from head to toe by Unit Manager on 4/26/2022. Resident suffered no negative outcome. MD/RP notified on 4/26/22 Dialysis kit will be placed at resident's bedside immediately but no later than 8/24/22 Resident # 182 was assessed from head to toe by Unit Manager ON 4/26/22. Resident suffered no negative outcomes. MD/RP notified on 4/26/22. Communication slips will be placed in resident's medical record immediately but no later than 8/24/22. Resident # 502 was discharged home on 6/2/22	

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F 698	Continued From page 268 Hypertension, Peripheral Vascular Disease, Acute Kidney failure, Systemic Inflammatory response syndrome, and Anxiety. Physician orders dated 03/28/22 directed, "Dialysis days remain the same Tuesday, Thursday, and Saturday everyday shift for ESRD Dialysis appointment..." A review of Resident #61's medical records from January 1, 2022, to March 23, 2022, showed that the resident dialysis record for communication between the dialysis center and the facility was not included as part of the resident medical record. Observation made on 04/14/22, at 9:10 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication records. All communication records for all dialysis residents for the second-floor units were observed to be placed in the same binder indicating that both records [medical and communication] mentioned were being maintained separately [not contained in the resident's medical record]. The evidence showed that the dialysis communication form was not included in resident#61's medical record but was maintained in a separate binder along with all the other resident that goes to dialysis information. During a face-to-face interview conducted on 04/14/22, at approximately 1:15 PM with Employee # 8 (Nurse Manager), He acknowledged the findings 2. Facility staff failed to ensure that the dialysis	F 698	F 698 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Dialysis residents residing in the facility have the potential to be affected, Charge Nurses, Supervisor / Designee will conduct house wide audit to ensure that dialysis communication slips are completed correctly, that there is a care plan indicating that resident has diagnosis for ESRD on HD, and that there is a dialysis emergency kit at bed side. Also, to ensure that dialysis communication slips are placed in the resident's medical records. Any issues found will be corrected by 8/24/22.	8/24/22

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F 698	Continued From page 269 communication form used to reflect ongoing collaboration between the facility and dialysis staff was completed with pertinent information for the resident's care and placed in Resident #95's medical record as a part of the record. Resident #95 was admitted to the facility on 02/11/22 with multiple diagnoses including End-stage Renal Disease, Anemia, Hypertension, Hyperlipidemia, Gastroesophageal Reflux Disease, Major Depressive Disorder, and Anxiety. Review of the Physician order dated 02/14/22 directed "Dialysis: Monday, Wednesday, Fridays, every day shift every ..." A review of Resident #95's medical records from March 1, 2022, to April 5, 2022, showed that the resident dialysis record for communication between the dialysis center and the facility was not included as part of the resident medical record. Observation made on 04/14/22, at 9:15 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication records. All communication records for all dialysis residents for the second-floor units were observed to be placed in the same binder indicating that both records [medical and communication] mentioned were being maintained separately [not contained in the resident's medical record]. Further review of the communication records showed that the following documentation of pertinent information for the resident care was left blank on the date mentioned in the communication record.	F 698	F 698 MEASURES TO PREVENT RECURRENCE: In -service will be provided by Staff Educator / Designee to all licensed nursing staff, on the importance to ensure that the dialysis communication slips are completed accurately, and that the communication slips are placed in the resident's medical record by 8/24/22. Unit Secretaries will ensure weekly that residents dialysis communication slips are placed in the resident's clinical record at the end of the month. Any issues found will be addressed by 8/24/22 Licensed staff nursing will ensure weekly that there is a dialysis emergency kit at bedside for the dialysis residents assigned to them. Any issues found will be addressed by 8/24/22 Charge Nurses will ensure that they fully complete the dialysis communication slip pre and post dialysis treatment on resident's dialysis day. Any issues found will be corrected by 8/24/22. Unit Managers will audit dialysis communication booklet weekly to ensure that the nurses are completing the form correctly. Any issues found will be corrected by 8/24/22 In service will be provided by staff educator to C N A, Licensed nurses, on the importance of always keeping dialysis emergency kit at bedside.	8/24/22

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F 698	Continued From page 270 "Date on communication record and Predialysis assessment time, and time the resident eats before dialysis" "03/02/22, 03/04/22, 03/07/22 Predialysis assessment time, and time the resident eats before dialysis" "03/09/22, time the resident eats before dialysis" "03/11/22, 03/14/22, 03/16/22 Predialysis assessment time, and time the resident eats before dialysis" "03/21/22, Predialysis and Post assessment time, and time the resident eats before dialysis" "03/23/22, code status, was medication given the day of dialysis" "03/25/22 was medication given the day of dialysis, Predialysis assessment time, time resident eats before dialysis" "03/28/22 Postdialysis time and completion assessment vital signs" "03/30/22, time the resident eats before dialysis, and post-dialysis assessment vital signs time" "04/01/22 was medication given the day of dialysis, post-dialysis assessment time" "04/04/22 was medication given the day of dialysis, Predialysis assessment time, time resident eats before dialysis" The evidence showed that the facility staff failed to ensure that the dialysis communication forms	F 698	Unit manager will ensure that resident #181 emergency dialysis kit is at bedside. Findings will be addressed by 8/24/22 Unit manager will ensure that resident #182 dialysis communication slip is filled out correctly to indicate medication administered prior to dialysis , assessment of the accesses site and time the resident left the unit. Findings will be corrected by 8/24/22 Charge nurse will ensure that resident #61.s dialysis communication slip is completed and is part of the resident's clinical record. Findings will be corrected by 8/24/22 Charge nurses will also ensure that they indicated on the communication slip if the resident ate before leaving for dialysis during their shift. Findings will be corrected by 8/24/22.	8/24/22

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F 698	Continued From page 271 were being completed and placed in the resident's medical record as part of the record. During a face-to-face interview conducted on 04/14/22, at approximately 1:15 PM with Employee # 8 (Nurse Manager), He acknowledged the findings 3. Facility staff failed to have an emergency kit at the bedside of Resident #181 who has an arteriovenous (AV) graft used for hemodialysis graft site. On 03/29/21 at approximately 4:00 PM, observation of Resident #181's nightstand, bedside table, closet, and dresser revealed that the resident did not have an emergency kit (pressure bandage) at her bedside. Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including End Stage Renal Disease. Review of a physician order dated 12/27/21 instructed, "Assess dialysis AV graft site for bruit & thrill every shift ..." Review of a Modification of Medicare 5-Day Minimum Data Set dated 03/22/22 showed the following: Section C (Brief Interview Mental Summary Score)- the resident had a summary score of "99" indicating the resident was unable to finish the interview. Section I (Active Diagnoses) The resident was coded for Renal Insufficiency, Renal Failure or End-Stage Renal Disease Section O (Special Treatment, Procedures, and Programs) - the resident was coded for receiving	F 698	MONITORING CORRECTIVE ACTIONS: DON/ Designee will conduct an audit on all dialysis communication booklets to ensure that the dialysis communication slips are completed accurately, that there is an emergency kit at resident's bedside and that the communication slips are placed in the resident's medical record. This exercise will be conducted weekly x4 then monthly x3. Findings will be corrected immediately and reported to QAPI committee.	8/24/22

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F 698	Continued From page 272	F 698		8/24/22

dialysis while not a resident and while a resident.

Review of care plan with a revision date of 05/31/21 showed the following:

Focus Area-[resident's name] need dialysis (hemodialysis) r/t (related to) ESRD (end-stage renal disease) 3 times/week on Tuesdays, Thursdays, and Saturdays.

During a face-to-face interview on 03/29/22 at approximately 4:05 PM, Employee #32 (LPN) stated that the resident recently moved to the room and the kit might have been left in the old room. It should be noted the surveyor and Employee #32 observed the resident's previous room and no kit was found.

4. Facility staff failed to ensure that the dialysis communication form used to reflect ongoing collaboration between the facility and dialysis staff was completed with pertinent information for the resident's care and placed in Resident #182 medical record as a part of the record.

Resident #182 was admitted to the facility on 11/30/21 with multiple diagnoses including Diabetes Mellitus, Hyperlipidemia, Chronic Viral Hepatitis C, Anemia, Hypertension, and Heart Failure.

Reviewed physician order dated 02/22/22 directed, "Dialysis: Tuesday, Thursday, Saturdays, every day shift every ..."

A review of Resident #182's medical records from March 1, 2022, to April 1, 2022, showed that the resident dialysis record for communication between the dialysis center and the facility was

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F 698	Continued From page 273	F 698		8/24/22

not included as part of the resident medical record.

Observation made on 04/14/22, at 9:25 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication records. All communication records for all dialysis residents for the second-floor units were observed to be placed in the same binder indicating that both records [medical and communication] mentioned were being maintained separately [not contained in the resident's medical record].

Further review of the communication records showed that the following documentation of pertinent information for the resident care was left blank on the date mentioned in the communication record.

"Date on communication record and Predialysis assessment time, and time the resident eats before dialysis"

"03/03/22 was medication given the day of dialysis, Predialysis assessment vital sign and time, access location, post-dialysis assessment time"

"03/05/22 was medication given the day of dialysis, Predialysis assessment time"

"03/07/22 "access location"

"03/11/22 Predialysis assessment time, time the resident eats before dialysis, post-dialysis assessment time"

"03/12/22 was medication given the day of

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F 698	Continued From page 274	F 698		8/24/22

dialysis, Predialysis assessment time, Problem noted or resident complaint"

"03/15/22 was medication given the day of dialysis, Predialysis assessment vital signs and time, access location, time the resident eats before dialysis, current diet and supplements, Problem noted or resident complaint"

"03/19/22 was medication given the day of dialysis, Predialysis assessment and time, time the resident eats before dialysis, Problem noted or resident complaint, post-dialysis assessment time, nurse signature"

"03/22/22 was medication given the day of dialysis, Predialysis Vital signs and assessment time, time resident eats before dialysis, Post dialysis assessment and time , nurse signature"

"03/23/22 was medication given the day of dialysis, Predialysis Vital signs and assessment time, time resident eats before dialysis, Post dialysis assessment and time , nurse signature"

"03/26/22, time the resident eats before dialysis, Problem noted or resident complaint and post-dialysis assessment vital signs time"

The evidence showed that the facility staff failed to ensure that the dialysis communication forms were being completed and placed in the resident's medical record as part of the record.

During a face-to-face interview conducted on 04/14/22, at approximately 1:15 PM with Employee # 8 (Nurse Manager), he acknowledged the findings

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DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

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F 698	Continued From page 275	F 698		8/24/22

4. Facility staff failed to ensure that the dialysis communication form used to reflect ongoing collaboration between the facility and dialysis staff was completed and placed in Resident #502's medical record as a part of the record.

Resident #502 was admitted to the facility on 03/17/22 with multiple diagnoses including End-stage Renal Disease, Anemia, Chronic Pancreatitis, Chronic Viral Hep-C, Hypertension, Peripheral Vascular Disease, Hyperlipidemia, and Cirrhosis of the Liver.

Review of the Physician order dated 03/17/22 directed, "Dialysis: Tuesday, Thursday, Saturday, every day shift every ..."

A review of Resident #502's medical records from March 1, 2022, to April 1, 2022, showed that the resident dialysis record for communication between the dialysis center and the facility was not included as part of the resident medical record.

Observation made on April 14, 2022, at 9:35 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication records. All communication records for all dialysis residents for the second-floor units were observed to be placed in the same binder indicating that both records [medical and communication] mentioned were being maintained separately [not contained in the resident's medical record].

Further review of the communication records showed that the following documentation of pertinent information for the resident care was left blank on the date mentioned in the

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F 698	Continued From page 276 communication record. "03/19/22 Predialysis assessment time, access location, and time the resident eats before dialysis" "03/24/22 was medication given the day of dialysis, Predialysis assessment time and Post dialysis assessment, nurses signature" "03/26/22 was medication given the day of dialysis, Predialysis assessment time" "03/29/22 Postdialysis assessment time returned and resident status" "03/31/22 was medication given the day of dialysis, Predialysis assessment time, Post dialysis assessment time" The evidence showed that the facility staff failed to ensure that the dialysis communication forms were being completed and placed in the resident's medical record as part of the record. During a face-to-face interview conducted on 04/14/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), He acknowledged the findings.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 726		

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F 726	Continued From page 277 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility staff failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety as evidence by failure to: (1) follow facility policy to make changes in Resident #56's active clinical record; (2) ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol Inhaler for Resident #181; and (3) address Resident #404's intrusive behavior which led to a resident-to resident altercation resulting in serious injury to Resident #404. The resident census on	F 726	F 726 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 56 was assessed from head to toe by Unit Manager on 4/26/2022. Resident suffered a hematoma on the left side of her forehead. X ray ordered and resident medicated for pain. MD/RP notified on 4/26/22.Changes will be made on residents' active clinical record by 8/24/22 Resident #181 was assessed from head to toe on 4/26 4/26/22. Resident is receiving her inhaler medication correctly. Resident # 404 was sent to the hospital 2/21/22 and expired.	8/24/22

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F 726	Continued From page 278 the first day of survey was 255. The findings include: Policy Title: "Correction in Resident Medical Records" revised 03/2022 documented, "...Procedure and Implementation- Whenever there is an error or multiple errors observed in resident(s) medical records or clinical chart. The facility will proceed as follows: The medical staff or clinical staff that made error in the resident electronic medical record must strike the error in documentation, and then document the reason why the documentation in being strike and sign and save. After striking the error in the electronic medical record of the resident, the medical staff or clinical staff will right an addendum for correct documentation if it is needed or appropriate. If the error in documentation occurred in resident(s) paper medical chart, the medical staff or clinical staff who made error will draw a line across the error, the staff will add his/her initial to the correction and add the date the error is crossed out. After the paper error has been corrected as above, the medical staff or clinical staff will write an addendum for correct documentation if it is needed or appropriate." 1. Facility staff failed to follow facility policy to make changes in the Resident #56's active clinical record. During a review of the chart on 04/07/22 at approximately 5:35 PM, the nursing progress notes dated 04/06/22 at 18:37 recorded "Resident was observed outside, in the parking lot, and on the floor. Upon the initial assessment, resident	F 726	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents in the facility have the potential to be affected by this practice. Clinical Care Coordinator, DON and Unit Managers will conduct house wide audit to ensure that the nurses are administering inhalers correctly to the residents. Any issues found will be addressed by 8/24/22. Also, they will ensure that licensed nurses are competent in administering medications via inhaler and understand how to address resident with intrusive behavior. Any issues found will be addressed by 8/24/22.. The clinical team will also ensure that changes to a resident's active clinical records are updated as indicated. Any issues found will be addressed by 8/24/22.	8/24/22

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F 726	Continued From page 279 was observed with a hematoma to the left side of her forehead. When asked what occurred, she informed the staff that she was attempting to get something off the floor and slid out of her wheelchair..." However, upon review of the nursing progress notes on 04/08/22 at 9:56 AM the following information related to the resident's incident was recorded, "On 4/6/2022 at 18:37 read, " ...The Security [Employee #46] was coming from the patio when she observed resident's wheelchair suddenly rolling into the parking lot. The Security chased after the wheelchair and resident, but resident ran into a car and fell. Resident said during interview, 'My wheelchair suddenly started rolling from the building into the parking lot, I was unable to stop it and into a car and hit my head." During a face-to-face interview with Employee #7 on 04/20/22 at 10:28 AM, he stated, with the documentation, "I was trying to document what actually happened. I was trying to document the actual occurrence." There was no evidence that when facility staff changed/altered the documentation in Resident #56's active clinical record that it was done in accordance with the facility policy. 2. Facility staff failed to ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol Inhaler for to one (1) resident. Resident # 181. Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease.	F 726	\MEASURES TO PREVENT RECURRENCE. In-service will be provided by DON to Staff Educator/ Designee on the importance to ensure that proper training is provided to all nurses and a competency check list is completed and signed by 8/24/22 Training will be provided to all Licensed nurses on how to administer medication via inhalers. Return demonstration will be required to validate understanding by 8/24/22 Targeted in-service was provided to employee #45 on 3/29/22 on how to administer medication via inhaler to the residents. Return demonstration indicated that training was effective. Unit Managers /supervisors will monitor licensed nurses on their units weekly to ensure that they are administering inhaler medication correctly. Any issues will be corrected by 8/24/22. Unit manager will observe employee as he/she administer medication via inhaler to resident #181. Findings will be corrected by 8/24/22	8/24/22

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F 726	Continued From page 280 During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer the inhaler for Resident #181. It should be noted the resident received the medication (inhaler) in the presence of the unit manager and surveyor. Review of a physician order dated 03/18/22 instructed, Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease). Review of the Medication Administration Record for March 2022 revealed that the following: Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day (9:00 AM) for COPD (Chronic Obstructive Pulmonary Disease) start date 03/18/2022. Employee #45 signed her initials indicating that she administered Resident #181 Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally at 9:00 AM on 03/18/22, 03/21/22-3/24/22, and 03/26/22 - 03/28/22. Review of Treatment Administration Record and Vital Summary sheet documented that Resident	F 726	Supervisors will conduct rounds weekly observing nurses as they administer medication via inhaler to ensure the process is done correctly. Any issues found will be corrected by 8/24/22. In-service will be provided to all Licensed nurses by staff educator/ Designee on the importance of updating a resident's active clinical records by 8/24/22. In service will be provided to all licensed nurses, C N A, Rehab staff, housekeeping staff by staff educator on the importance of monitoring residents with intrusive behavior on the units every shift. DON/Designee will audit charts of residents with intrusive behavior weekly and ensure that interventions are implemented by the nurses and CAN'S to ensure safety to resident and others. Will also ensure that the care plans for residents who have intrusive behavior(wandering) are revised/ updated. Findings will be corrected by 8/24/22 DON/Designee will ensure weekly that new employees have completed their nursing competency skill check list and are able to demonstrate what they have studied. Failure to carry out return demonstration of medication administration will result to reeducation by the staff educator.	8/24/22

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F 726	Continued From page 281 #181's oxygen saturation rate ranged from 96-98% on room air from 03/18/22 to 03/21/22 and respiration rate ranged from 17 to 20 breaths per minute from 03/18/22 to 03/24/22. During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that 03/29/22 was the first time she administered Tiotropium Bromide Monohydrate Aerosol inhaler because she did not know how to administer it. When ask why did she initial that she administered prior to 03/29/22? She said, "It was an error." The employee also stated that she did not make anyone aware she did not know how to administer that type of inhaler. 3. Facility staff failed to demonstrate competent nursing skills sets to assure resident safety as evidenced by failure to address Resident #404's intrusive behavior which led to an altercation that resulted in serious injury to Resident #404. Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, "...The charge nurse observed [Resident 404] sitting on the floor besides his roommate's... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..." Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a	F 726	Staff educator will ensure that new licensed nurses are well trained on how to address residents with intrusive behavior, what to do if a resident is exhibiting intrusive behavior and what documentation need to be in place. Findings will be addressed by 8/24/22. DON/ Designee will monitor licensed nurse and assist in validating the completion of the medication administration check list during orientation Paying close attention to administering medication vis inhaler. Findings will be corrected by 8/24/22. Unit manager will ensure that corrections on residents # 56 active record is updated and that the care plan id updated to reflect the changes made.by 8/24/22. Unit manager/designee will ensure that nurses are completing incident reports for intrusive residents correctly and that they must indicate where and when the incident took place and those involved in the incident. Findings will be corrected by 8/2422 In service will be provided to all licensed nurses on how to correct a documented error by 8/9/22 Coaching and counselling will be provided to nurses who are not in compliance with medication administration by staff educator.	8/24/22

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F 726	Continued From page 282 nursing home in the District. [Representative's Name] ... in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..." Review of a Complaint dated 03/31/22 documented, "...Avoidable death. Comments: Patient assaulted in nursing home. Beneficiary was assaulted 02/22/2022 in skilled nursing facility by another resident. He sustained blunt head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died ..." Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack. During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, " ... Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D [Resident #404] Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed ..." Review of Resident #404's medical record revealed the following: 12/16/21 [Quarterly MDS] showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment.	F 726	MONITORING CORRECTIVE ACTION DON/Designee will conduct random rounds to ensure that nurses are administering medication correctly and ensure that the competency check list for medication administration is completed and signed by the nurses. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI committee	8/24/22

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F 726	Continued From page 283	F 726		8/24/22

In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily"

In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion

In Section P (Restraints and Alarms), wander/elopement alarm, "Used daily"

Care Plan: 07/27/21 (Revision date) ["Resident #404 is at risk for Elopement: cognitive impairment, dementia ... Observed wondering at the adjacent unit on 5/28/2021. Wandering to the adjacent unit on 7/3/21. Redirected easily. Wandering to the adjacent unit on 6/8/2021. Easily redirected. Wondering on 7/11/2021. Redirected. Wondering to the adjacent unit 7/27/2021, Easily redirected ... Avoid leaving unattended or unobserved for long periods of time. Hourly elopement/wandering monitoring and location."

Review of the Daily Behavior Documentation showed the following:

02/02/22 at 2:12 PM "... Elopement attempts. Wandering ....sleeping in other people's bed... Behaviors are constant."

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F 726	Continued From page 284 02/03/22 at 1:12 PM "... sleeping in other people bed. Behaviors are constant." 02/07/22 at 1:52 PM "... sleeping in other people's bed. Behaviors are constant." 02/09/22 at 1:47 PM "...sleeping in other peoples bed. Behaviors are constant." 02/10/22 at 12:17 PM "...sleeping in other peoples bed...Behaviors are constant." 02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant." 02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant." 02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant." 02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant." 02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant." 02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant." Situation Background Assessment Request (SBAR): 02/21/22 at 4:00 AM "Situation... The resident got hit by his roommate...The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face ...The writer asked	F 726		8/24/22

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F 726	Continued From page 285	F 726		8/24/22

[Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware."

This evidence showed:

a. Although the facility had a care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revised to address the residents intrusive behavior (wandering into other resident rooms and sleeping in their beds).

b. Facility staff failed to document the names, room numbers of residents who were affected by Resident #404's behavior; and failed to assess how Resident #404's behavior impacted other residents such as putting himself or others at risk for physical injury, intrusion on their privacy or activity, upset that he in their room and sleeping in their bed.

c. Although the staff record that Resident #404 was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that monitoring the resident was readjusted to manage the residents behavior.

During a face-to-face interview conducted on 04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) stated, "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make

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F 726	Continued From page 286 updates as needed." When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in other resident's beds, Employee #7 stated, "I was never made aware by the nurses on the unit. I knew him [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation ..." that stated Resident #404's behavior, Employee #7 stated, "I didn't see it."	F 726		8/24/22
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 732	F732; CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this practice IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: None	

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DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

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F 732	Continued From page 287 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility staff failed to record the total number of staff worked and the hours per patient day for one day on the "Report of Nursing Staff Directly Responsible for Resident Care" form; and failed to maintain 18 months of the posted daily nurse staffing data. The resident census on 04/14/22 was 245. The findings include: Review of the "Report of Nursing Staff Directly Responsible for Resident Care" form dated 04/14/22 showed the following: Total Census: 245 Number of RN (Registered Nurses) for 7 AM - 3:30 PM - 6 Number of RNs for 3 PM -11:30 PM - 4 Number of RNs for 11 PM -7:30 AM - 3	F 732	F 732 MEASURES TO PREVENT RECURRENCE: In-service will be provided by Staff Educator /Designee to the Staffing coordinator to always ensure that the total number of hours worked per day by the nursing staff who are providing direct patient care is recorded. Also , that all staffing records must be maintained. per facility's policy by 8/24/22. Human Resources Manager's assistant will audit staffing records weekly to ensure the staffing coordinator is recording the actual number of nursing staff directly responsible for resident's care. Any issues found will be corrected by 8/24/22. Human Resources Director will conduct audit to ensure that the staffing coordinator is posting a report of nursing staff directly responsible for residents care correctly. Any issues found will be corrected by 8/24/22. Human Resource Manager will ensure that staffing records are preserved monthly. Any issues found will be corrected by 8/24/22. The Administrator will ensure staffing records are retained every three months.	8/24/22

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F 732	Continued From page 288 Number of LPNS (Licensed Practical Nurses) for 7 AM - 3:30 PM - 6 Number of LPNs for 3 PM -11:30 PM - 5 Number of LPNs for 11 PM -7:30 AM - 4 Number of CNA (Certified Nurse Aides) for 7 AM - 3:30 PM - 22 Number of CNAs for 3 PM -11:30 PM - 24 Number of CNAs for 11 PM -7:30 AM - 20 Actual Hours (the total) was left blank; and there were numbers entered for hours per patient day (PPD). The facility's "Nursing Staff Directly Responsible for Resident Care" report list the number of hours the RNs, LPNs and CNAs worked, but failed to record the total number of disciplines under the actual hours and record the PPD. During a face -to-face interview conducted on 04/14/22 at approximately 3:43 PM, Employee #20 stated that she reviewed the form and acknowledged the findings. The Writer asked to see proof that the facility maintained 18 months of the posted nurse staffing data. Employee #20 stated the facility was unable to showed proof that they maintained the forms.	F 732	MONITORING CORRECTIVE ACTION: Human Resources Director / Designee will conduct audits to ensure that the staffing coordinator is recording the actual number of staff directly responsible for patient care correctly and that records are maintained per policy. This audit will be done weekly x 4, then monthly x3. Findings will be corrected immediately and reported to QAPI committee.	8/24/22
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by	F 741		

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F 741	Continued From page 289 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 105 sampled residents, facility staff failed to: monitor and provide ongoing assessment of the effectiveness of interventions for a resident with a mental or psychosocial disorder; and demonstrate reasonable attempts were made to implement approaches to help meet the behavioral health needs to assure resident safety. Resident #404. The findings include: Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, "...The charge nurse	F 741	F 741 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 404 was sent to the hospital on 2/21/22 and later expired. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. DON/ Designee will conduct house wide audit to ensure that the nurses are monitoring and providing ongoing assessments and interventions for residents with behavior issues. Any issues found will be corrected by 8/24/22.	8/24/22

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F 741	Continued From page 290 observed [Resident 404] sitting on the floor besides his roommate's ... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..." Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's Name] ... in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..." Review of a Complaint dated 03/31/2022 documented, "...Avoidable death. Comments: Patient assaulted in nursing home. Beneficiary was assaulted 02/22/2022 in skilled nursing facility by another resident. He sustained blunt head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died ..." Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack. During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility	F 741	F 741 MEASURES TO PREVENT RECURRENCE: In-service will be provided by Staff Educator/ Designee to Licensed Nurses on the importance to ensure that residents with behavior are monitored and supervised during their shift by 8/24/22 Competency check list will be completed by Licensed nurses to indicate that they understand how to provide care to residents with aggressive behavior by 8/24/22. ADON/Designee will ensure that nurses are monitoring and supervising residents with aggressive behavior during their shift. Any issues found will be corrected by 8/24/22 Unit Mangers will validate that resident with behavior problems are monitored and supervised every shift, and that there is documentation to justify supervision. Any issues found will be addressed by 8/24/22. Charge nurses will conduct rounds to ensure that residents with aggressive behavior are being supervised every shift. Any issues found will be addressed by 8/24/22	8/24/22

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F 741	Continued From page 291 document was observed taped to a partition at the nurses station that stated, " ... Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D [Resident #404] Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed ..." Review of Resident #404's medical record revealed the following: 12/16/21 [Quarterly MDS] showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment. In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily" In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion In Section P (Restraints and Alarms), wander/elopement alarm, "Used daily" Care Plan: 07/27/21 (Revision date) ["Resident #404 is at risk for Elopement: cognitive impairment, dementia ... Observed wondering at the adjacent unit on 5/28/2021. Wandering to the adjacent unit on 7/3/21. Redirected easily.	F 741	Unit Managers will assess residents and determine if they qualify for one-on-one supervision secondary to aggressive behavior. If a resident is qualified, that one-on-one services will be provided until seen by the psych doctor. Unit Managers will ensure that every intervention in the care plan for intrusive behavior is being implemented. Any issues found will be corrected by 8/24/22 Education will be provided to residents with a BIMS score of 12 and above to report any resident who is intrusive to the charge nurses or CNA's. Hourly rounds will be conducted by Licensed nurses and CNA during their shift to monitor residents who are non-verbal or unable to identify an intruder. Any identified intruder will be redirected out of the room and supervised. Any issues found will be corrected by 8/24/22 Family members will be updated if their loved one is exhibiting intrusive behavior either through mail or telephone or in-person during interdisciplinary meetings. Documentation of intrusive behavior will be in place, plan of care updated, and implementations carried out as indicated. Any issues found will be corrected by 8/24/22	8/21/22

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F 741	Continued From page 292 Wandering to the adjacent unit on 6/8/2021. Easily redirected. Wondering on 7/11/2021. Redirected. Wondering to the adjacent unit 7/27/2021, Easily redirected ... Avoid leaving unattended or unobserved for long periods of time. Hourly elopement/wandering monitoring and location." Review of the Daily Behavior Documentation showed the following: 02/02/22 at 2:12 PM "... Elopement attempts. Wandering ....sleeping in other people's bed... Behaviors are constant." 02/03/22 at 1:12 PM "... sleeping in other people bed. Behaviors are constant." 02/07/22 at 1:52 PM "... sleeping in other people's bed. Behaviors are constant." 02/09/22 at 1:47 PM "...sleeping in other peoples bed. Behaviors are constant." 02/10/22 at 12:17 PM "...sleeping in other peoples bed...Behaviors are constant." 02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant." 02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant." 02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant."	F 741	MEASURES TO PREVENT RECURRENCE CONTINUE Charge nurses will ensure that residents with at risk for elopement are monitored and supervised during their shifts. Findings will be addressed by 8/24/22. Unit managers will also ensure that residents on elopement monitoring and must have their wander guard band always. Findings will be corrected by 8/24/22. Charge nurses and CN A 's will ensure that they redirect residents who are wandering during their shifts. Findings will be corrected by 8/24/22. Unit managers will ensure that residents who wander are assessed by psych doctor for further evaluation and treatment and their care plans revised/ updated. Findings will be corrected by 8/24/22. Clinical care coordinator will audit charts for residents with behavior to ensure that plan of care is being implemented weekly. Findings will be corrected by 8/24/22	8/24/22

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F 741	Continued From page 293 02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant." 02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant." 02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant." Situation Background Assessment Request (SBAR): 02/21/22 at 4:00 AM "Situation... The resident got hit by his roommate...The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face ...The writer asked [Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware." This evidence showed: a. Although the facility had a care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revised to address the residents intrusive behavior (wandering into other resident rooms and sleeping in their beds). b. Although the staff record that Resident #404 was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that monitoring the resident was readjusted to manage the residents behavior.	F 741	MONITORING CORRECTIVE ACTION: DON/Designee will conduct audits to ensure that residents are accounted for, monitored, and supervised every shift. This audit will be conducted weekly x4, then monthly x3. Findings will be addressed immediately and reported to QAPI committee.	8/24/22

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F 741	Continued From page 294 During a face-to-face interview conducted on 04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) stated, "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make updates as needed." When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in other resident's beds, Employee #7 stated, "I was never made aware by the nurses on the unit. I knew him [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation ..." that stated Resident #404's behavior, Employee #7 stated, "I didn't see it."	F 741		8/24/22
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	F755 CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENTS: No resident was affected by this practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected	

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F 755	Continued From page 295 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to ensure that the system used for the reconciliation of controlled medications was followed; and failed to accurately reconcile controlled medications for three (3) of 16 records reviewed. Residents' #151 and #188. The findings include: The facility's policy and procedures for the storage of controlled substances revised on 08/2020 stated: Policy: "Medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations ...Procedures: ...Unless otherwise indicated...the following will be performed"... At each shift change, or when keys are transferred, a physical	F 755	MEASURES TO PREVENT RECURRENCE: The Director of Nursing will create a new control substance form that will enable accurate reconciliation and accounting of all controlled substances by 8/24/22. In service will be provided by Staff Educator/ Designee to all licensed clinical staff on how to use the new Control substance form and education on how Diazepam will be counted, one of two vials, two of two vials by 8/24/22. Unit Managers will ensure that nurses are using the newly created control form accurately and that there are no holes on the form during their shift. Any issues will be corrected by 8/24/22 Nurse Supervisors will conduct audits weekly to ensure that the nurses are utilizing the control substance form accurately. Any issues will be corrected by 8/24/22 ADON and Clinical Coordinator will conduct random rounds to ensure that the nurses are completing the narcotic count sheets correctly. Any issues found will be addressed by 8/24/22	8/24/22

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F 755	Continued From page 296 inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel and is documented ... Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and documented on a Control Count Sheet (or similar form) or in accordance with facility policy..." 1. Facility staff failed to have a system of medication records that enables accurate reconciliation and accounting for all controlled medications. During an observation on 03/31/22 at 11:02 AM of Medication Cart 2 on unit 4 South, there was two (2) residents (Residents' #151 and #188) with ordered "Diazepam (antianxiety) 10 MG (milligram) rectal gel". The package was observed with two (2) doses (20 MG in total) however, the narcotic book showed, "amount received 1". On 03/31/22, starting at 11:18 AM, observation medication cart #1 (narcotic box) revealed two (2) residents with Diazepam rectal gel kits. Each kit contained two (2) gel syringes of Diazepam 10 milligrams each. However, the staff reconciled the two syringes as one (1) kit on the Controlled Drug Administration Record. During a face-to-face interview on 03/31/22 at 11:44 AM, Employee #61 (Registerd Nurse) stated that the syringes are counted as one (1) and the 2nd syringes is destroyed if not used. Further review of the Controlled Drug Administration Record revealed a physician order that directed, "Insert 10 mg (milligrams) rectally as needed for seizure. Administer 1 with initial	F 755	F755 MONITORING CORRECTIVE ACTION: DON/Designee will conduct audits on all the units to ensure that the nurses are using the controlled medication sheet accurately and that all control substances are always accounted for. This audit will be conducted weekly x4, then monthly x3. Findings will be addressed immediately and reported to QAPI committee.	8/24/22

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seizure, then repeat in 4 hrs. (hours) once call MD (medical doctor) if ineffective."

During a face-to-face interview conducted on 03/31/22 at 12:02 PM with Employee #2 (DON), she stated, "I spoke to the pharmacist and asked about the Diazepam, she stated they are counting just the kit as 1 not the number of doses." When asked how the facility accounts for the other dose once one dose is administered, Employee #2 stated that she wasn't sure.

During a telephone interview, the facility's contracted pharmacist on 03/31/22 at 3:18 PM stated that the two syringes in the Diazepam kit are counted as one because the manufacturer "denotes the kit as one (1)."

2. The facility staff failed to ensure that the system used for the reconciliation of controlled medications was followed on three (3) occurences.

2A. During a tour on the 2 South unit of the facility on 03/29/22 at approximately 12:00 PM, a review of the narcotic card count sheets for Medication Cart #1 revealed the following:

On 02/26/22, 03/05/22, 03/08/22, 03/15/22, 03/17/22, and 03/19/22 (6 days), the same licensed nurse signed off as Nurse #1 and Nurse #2, instead of two different nurses signing off that the narcotic card count sheets were correct.

On 03/06/22, only one licensed nurse (Nurse #1) signed off. The space for the second licensed nurse to sign (Nurse #2) to sign was left blank.

On 03/07/22, only one licensed nurse (Nurse #2)

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signed off. The space for Nurse #1 to sign was left blank.

During a face-to-face interview with Employee #2 (DON) on 03/29/22 at 12:30 AM, she stated that when the nurses worked a double shift, the same nurse signed as Nurse #1 and Nurse #2 on the narcotic card count sheets. "I can see how the form (narcotic card count document) is confusing. I am going to be making changes to that."

2B. During a tour on the 5 North unit on 03/31/22 at approximately 10:00 AM, a review of the controlled drugs shift-to-shift count record for Medication Carts #1and #2 revealed the following:

Medication Cart #1: On 03/05/22, 03/06/22, 03/18/22, and 03/19/22, one licensed nurse signed the controlled drugs shift-to-shift count record for two shifts 7:00 AM-3:30 PM and 3:00 PM-11:30 PM.

Medication Cart #2: On 03/06/22, 03/11/22, 03/12/22,03/19/22, 03/26/22, and 03/27/22, one licensed nurse signed the controlled drugs shift-to-shift count record for two shifts 7:00 AM-3:30 PM and 3:00 PM-11:30 PM.

During a face-to-face interview with Employee #2 (DON) on 03/31/22 at 10:35 AM, the employee reviewed the controlled drug shift to shift count record. She then stated, "The only problem that I can see is that they (licensed nurses) may have asked another nurse to count with them and I'm not sure where they are documenting that." She could not provide documented evidence that two licensed nurses conducted a physical inventory of all controlled substances and documented it at

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each shift change, as stated in the facility's policy.

2C. The facility staff failed to ensure that the system used for the reconciliation of controlled medications was followed.

*A review of the Shift count Narcotic records on Unit 2 North was completed on 04/12/22, at approximately 10:00 AM. The review showed that on April 1 - 12, 2022, the Shift count Narcotic sheet had one nurse's signature was placed in the spaces allotted for one nurse going off duty and one nurse coming on duty to reconcile the Narcotics together for the 7:30 AM to 3:30 PM shift, and 3 PM - 11:30 PM.

*A review of the Shift count Narcotic records on Unit 2 South was completed on 04/12/22, at approximately 10:10 AM. The review showed that on April 1, 2022, 3p-11:30P and 11P -7:30A shift, and on April 4, 2022, 7a -3:30P Shift count Narcotic sheet had one nurse signature in the spaces allotted to the nurses going off duty and coming on duty to reconcile the Narcotics together.

A review of the Shift Verification of Accuracy of Controlled Drug Record to the Actual Narcotic Count [Reconciliation Controlled Drug Count Verification Form] directed, "Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift"

The evidence showed only on nurse's signature was found signing off duty and on duty on unit 2 north on April 1 -12, 2022 and Unit 2 South on April 1, 2022, and April 4, 2022, indicating that the system's use for an acceptable standard of

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F 755	Continued From page 300 practice to account for the receipt, usage, disposition, and reconciliation of controlled medications were not followed. A face-to-face interview was conducted with Employee #8 on 04/12/22, at approximately 11:10 AM. After a review of the documentation, he acknowledged the findings.	F 755		8/24/22
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		

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F 756	Continued From page 301 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for six (6) of 105 sampled residents, facility staff failed to: (1) show documented evidence that the attending physician or designee reviewed the monthly medication regimen review and that they acted upon the pharmacists' recommendations. Residents' #16, #22, #61, #167, #190, #238 The findings include: Review of the facility policy entitled, "Medication Regimen Review", dated 08/2020 documented, "... Recommendations are acted upon and documented by the facility staff and/or prescriber. The prescriber accepts and acts upon recommendation or rejects provides an explanation for disagreeing ... The Director of Nursing or designated licensed nurse address and document recommendations that do not require a physician intervention, e.g., monitor blood pressure..." 1. Facility staff failed to act upon the pharmacist recommendation to "Please eval Risperdal for a GDR (gradual dose reduction)..." for Resident #16.	F 756	F756 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #22 was assessed from head to toe by Unit Manger on 4/26/22. Resident suffered no negative outcome. MD/RP notified on 4/26/22. Monthly reviews will be implemented immediately but no later than 8/24/22. Resident # 61 was assessed from head to toe by Unit manager on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. Monthly reviews will be implemented immediately but no later than 8/24/22. Resident #167 was assessed from head to toe on 4/18/22, resident suffered no negative outcome . MD/RP notified on 4/26/22. Monthly reviews will be implemented immediately but no later than 8/24/22. Resident # 190 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. Monthly reviews will be implemented immediately but no later than 8/24/22. Resident # 238 was assessed from head to toe on 4/26/22,resident suffered no negative outcome.. MD/RP notified on 4/26/22. Monthly reviews will be implemented immediately but no later than 8/24/22. Resident # 16 was assessed from head to toe by Unit Manager on 4/26/22, resident suffered no negative outcome/RP notified on 4/26/22. Monthly reviews will be implemented immediately but no later than 8/24/22.	8/24/22

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F 756	Continued From page 302 Resident #16 was admitted to the facility on 03/14/08, with multiple diagnoses that included: Type 2 Diabetes Mellitus with Hyperglycemia, Heart Failure, Major Depressive Disorder Recurrent Severe Without Psychotic Features, and Dementia in Other Diseases Classified Elsewhere Without Behavioral Disturbance. Review of the Quarterly Minimum Data Set (MDS) dated 03/24/22, revealed: In Section C (Cognitive Patterns) C0100 "Should Brief Interview for Mental Status ... be Conducted?" Facility staff coded "0" No. In Section N (Medications): N0410 "Indicate the number of days the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days." Facility staff coded Resident #16 as receiving Antipsychotic, Antidepressant, Anticoagulant and Diuretic during the last 7 days. N0450 "Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment whichever is more recent? Facility staff coded "1" No "Has a gradual dose reduction (GDR) been attempted?" Facility staff coded "0" No. "Physician documented GDR as clinically contraindicated" Facility staff coded "0" No. N2001 "Drug Regiment Review" This section was blank. Review of the physician's orders revealed the following:	F 756	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All residents residing in the facility have the potential to be affected. DON/ Designee will conduct house wide audit to ensure that all pharmacy recommendations are addressed in a timely manner. Any issues found will be corrected by 8/24/22 ADON will conduct an audit to ensure that attending physicians / Designee are reviewing pharmacy recommendations and are signing off on it in a timely manner to avoid delays in treatment. Any issues found will be corrected by 8/24/22	~~8/24/22~~

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F 756	Continued From page 303 05/21/20, Escitalopram Oxalate Tablet 20 MG give 1 tablet orally one time a day for depression" 06/23/21, "Risperdal tablet 1 MG (risperidone) give 1 tablet by mouth two times a day for psychotic disorder." Review of Resident # 16's Electronic Health Record revealed a pharmacy drug regimen review was conducted on 12/19/21, 01/18/22, 02/14/22, 03/15/22. On these assessments an oval was marked that stated "Recommendations given to the IDT (Inter-disciplinary team). The pharmacy drug regimen review dated 12/19/21, recommendations are "Please eval Risperdal for a GDR especially with a psychotic dx." There is no documented evidence in the medical record of the physician responding to this recommendation. During a telephone interview conducted on 04/19/22 at 10:49 AM, with Employee #23 (Consultant Pharmacist) stated, "Once we submit a report, we give a page to each doctor to respond." During a face-to-face interview conducted on 04/19/22 at 1:11 PM, with Employee #2 (Director of Nursing) stated, "I didn't see a note." Employee #2 acknowledged there was no documented evidence that a physician reviewed or responded to the pharmacist recommendation. 2. Facility staff failed to show documentation that the attending physician or designee reviewed the monthly medication regimen review and act on	F 756	F 756 MEASURES TO PREVENT RECURRENCE. In -service will be provided by Staff Educators to all licensed nursing staff to ensure that they follow up with pharmacy recommendations promptly by 8/24/22. Supervisors will audit residents' chart monthly to ensure that nurses are calling physicians/ Designee with recommendations from the Pharmacist. Any issues found will be corrected by 8/24/22 DON's secretary will ensure that all pharmacy recommendations are printed out and handed to the Unit Managers for follow up on a weekly basis. Any issues found will be addressed by 8/24/22. Unit Managers will ensure weekly that the physicians sign the pharmacy recommendation slip and that there is documentation to validate review. Any issues found will be corrected by 8/24/22. ADON will ensure on a weekly basis that all pharmacy recommendations have been printed out and that the Licensed nurses are following up with the physicians to address the recommendations. Any issues found will be corrected by 8/24/22	8/24/22

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F 756	Continued From page 304 the recommendations for Residents' #22, #61, #167, #190 and #238.. 2A. Resident #22 was admitted to the facility on 11/09/15 with multiple diagnoses that included Hypertension, Anemia and Hyperlipidemia. Review of Resident #22's medical record revealed: An Annual Minimum Data Set (MDS) dated 03/23/22 showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "10", indicating moderate cognitive impairment. 02/04/20 (Revision date) [Care Plan] "[Resident #22] is, at risk for adverse reaction r/t (related to) polypharmacy ... Review Pharmacy consult recommendations and follow up as indicated. 02/04/20 (Revision date) [Care Plan] "[Resident #22] receives 9 or more different medications and is at risk for adverse drug interactions ... Clinical pharmacist medication review monthly and prn. Inform physician of recommendations..." MRR form for December 2021 read,"Every three (3) months labs overdue". There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed. MRR form for January 2022 read, "month (every month) Keppra (antiseizure) overdue". There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.	F 756	Unit manager will ensure that monthly review for resident #22 is reviewed by the physician and signed off on it. Findings will be corrected by 8/24/22 Unit manager will ensure that monthly recommendation on the GDR for resident # 16 is addressed by the physician and documentation in place by 8/24/22 Charge nurse will ensure that monthly pharmacy recommendation for resident # 167 is addressed by the physician to signed by 8/24/22 Unit manager will ensure that monthly pharmacy recommendation for resident #190 will be addressed by the physician by 8/24/22 Unit manager will ensure that the physician addresses resident # 238's monthly pharmacy review by 8/24/22 Don/Designee Will ensure that all monthly pharmacy reviews are printed out, addressed by the physician in a timely manner. Findings will be addressed by 8/24/22	8/24/22

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F 756	Continued From page 305 2B. Resident #61 was admitted to the facility on 11/06/20 with multiple diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Viral Hepatitis C, Anemia, Hypertension, Peripheral Vascular Disease, Acute Kidney failure, Systemic Inflammatory response syndrome, and Anxiety. A review of Resident #61's medical record showed that from July 2021 to February 2022, the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's signature and the date and response area, were left blank, indicating it was not reviewed. 2C. Resident #167was admitted to the facility on 10/25/19 with multiple diagnoses including end-stage Renal Disease, Anemia, Hyperlipidemia, Hypertension, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, and anxiety. A review of Resident #167's medical record showed that from June 2021 to February 2022, the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's signature and the date and response area, were left blank, indicating it was not reviewed. 2D. Resident #190 was admitted to the facility on 11/27/21 diagnoses that included: End Stage	F 756	MONITORING CORRECTIVE ACTION: DON / Designee will conduct house wide audit to ensure that pharmacy recommendations are reviewed by the attending physician and that there is adequate documentation validating review. This audit will take place weekly x4, then monthly x3. Findings will be corrected and reported to QAPI Committee.	8/24/22

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Renal Disease, Hypertensive Emergency, Pressure Induced Deep Tissue Damage of the Sacral Region, Diabetes Mellitus and Anxiety.

Review of Resident #190's medical record revealed:

MRR form for December 2021, read "... could 80mg (milligram) Atorvastatin (cholesterol reducer) be reduced?" There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

MRR form for February 2022, read "... suggest Darbopoetin (antiplatelet) state 'give at HD (hemodialysis) clinic." There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

MRR form for March 2022 read, "Please eval (evaluate) Buspar (antianxiety) ... for serotonin effects ..." There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

2E. Resident #238 was admitted to the facility on 10/28/20 with the following diagnoses: Diabetes Mellitus, Hypertension, Cirrhosis of the Liver, Hyperlipidemia, Gastro-esophageal Reflux Disease, Chronic Hepatitis, Cerebral Infarction and Dysphagia, Dementia with behavioral.

A review of Resident #238's medical record showed that from October 2021 to March 2022, the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted

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F 756	Continued From page 307 on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's signature and the date and response area, were left blank, indicating it was not reviewed. During a telephone interview conducted on 04/19/22 at 10:55 AM, Employee #23 (Consultant Pharmacist) was asked about the MRRs for each of the aforementioned residents, to which she stated, "The MRR report forms are submitted to the Administrator, Director of Nursing (DON) and the Unit Managers. They are distributed to the appropriate physician or Nurse Practitioner (NP). Once a response is provided (agree, disagree, other) it goes into the patients chart as part of their permanent record." During a face-to-face interview conducted on 04/19/22 at 1:11 PM, Employee #2 (DON) acknowledged the findings that Resident #22's, #167's, #190's and #238's MRR were not reviewed. Employee #2 further stated, "At this time, I review the MRRs. They are printed out and given to the assigned Unit Manager who notify the MD (medical doctor) or NP (Nurse Practitioner). Sometimes the recommendations don't require any action. Once they (MD/NP) review and sign the MRR form, it is filed." When asked why facility staff failed to document agree, disagree, or other and why there was no physician or designee signature on the medication review form to indicated that it was reviewed, Employee #2 stated, "There is no specific time frame for the reviews to be done, but we try to get them done as soon as possible."	F 756		8/24/22
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 308 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, facility staff failed to ensure that medications and biologicals were properly labeled and stored for three (3) of 16 medication carts. The findings include: The facility's policy and procedures for storage of medications revised on 08/2020 stated, "...Medications and biologicals are stored safely, securely, and properly following manufacturer's	F 761	F 761 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No Resident was affected by this practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents residing in the facility have potential to be affected. DON/ Designee will conduct audit on all carts to ensure that all medications are correctly labeled and stored properly. Any issues found will be corrected by 8/24/22	8/24/22

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F 761	Continued From page 309 recommendations or those of the supplier... Procedures: III. Expiration Dating (Beyond-Use Dating) ... When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated... The nurse shall place a "date opened" sticker on the medication and record the date opened, and the new date of expiration. The expiration date of the vial or container will be 30 days from opening unless the manufacturer recommends another date ... If a vial or container is found without a stated date opened, the date opened will automatically default to the date dispensed, and the expiration date will be calculated accordingly...All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of the amount remaining ..." 1. Facility staff failed to accurately label and safely store medications. A. During a tour and observation on the 2 South unit on 03/29/22 at approximately 12:00 PM of Medication Cart #1, the following was noted: one (1) Lantus Insulin pen with no date of when it was first opened, was stored for use; one resident's Humalog Insulin pen was observed stored in a bag labeled Glargine (Lantus) 100 units per ml pen and one (1) vial of Lispro Insulin with no date indicating when it was opened. During a face-to-face interview with Employee #41 (Registered Nurse) on 03/29/22 at approximately 12:00 PM, she acknowledged that the Insulin pens and Insulin vial were not stored correctly and discarded the items. 2.	F 761	F 761 MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Development team/ Designee to all licensed nursing staff to ensure that medications are labeled and stored correctly by 8/24/22. MDS team has been assigned to ensure that medications are labeled and stored correctly for safety purposes. This audit will be done during ground rounds daily. Any issues found will be corrected by 8/24/22. Charge nurses will ensure that they audit their carts on a weekly basis to ensure that medications are labeled and stored appropriately. Any issues found will be corrected by 8/24/22 ADON/Designee will conduct random rounds on a weekly basis to ensure that medications are labeled and stored correctly. Any issues found will be corrected by 8/24/22 Supervisors will ensure that medication carts are clean and that the medications are stored correctly on a weekly basis. Any issues found will be corrected by 8/24/22 Licensed Nurses who are found to be non-compliant will be provided coaching and counseling and will be sent to staff developers for re in-service. This is completed by 8/24/22. Repeat coaching and counseling provided as needed.	8/24/22

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F 761	Continued From page 310 B. During an observation on 03/30/22 at 11:11 AM on Unit 4 South, Medication Cart #1, the following was noted: three (3) vials of Insulin stored for use that had expiration dates of "2/22/22, 2/27/2022 and 3/25/22", three (3) open vials of Insulin with no date opened or expiration date, one (1) and two (2) blister packets of Lorazepam (antianxiety) 1 MG for a resident who was discharged on 03/15/22. During a face-to-face interview conducted at the time of the observation, Employee #47 (LPN) acknowledged the findings and stated, "This isn't my usual floor. I work upstairs." During a face-to-face interview conducted on 04/19/22 at 10:55 AM, Employee #23 (Consultant Pharmacist) stated, "Narcotic medications that have been discontinued or if the patient is discharged, have to be returned to the pharmacy or be destroyed by 2 licensed staff. They are not to be stored in the medication cart or medication storage room." C. During an observation on 03/31/22 at 10:18 AM on Unit 4 North, Medication Cart 1, the following was noted: three (3) vials of Insulin stored for use that had expiration dates of "2/210/22, 2/10/2022 and 2/22/22", three (3) Insulin pens and one (1) vial no date opened or expiration date. During a face-to-face interview at the time of the observation, Employee #48 (LPN) acknowledged the findings and stated that licensed staff are provided education on putting dates when they open a new Insulin vial or pen.	F 761	MONITORING CORRECTIVE ACTIONS: DON/ Designee will conduct audits on all medication carts to ensure that the medications are labeled and stored correctly. This audit will be done weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI Committee	8/24/22
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 311 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 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 observation and staff interview, facility staff failed to serve and distribute foods in accordance with professional standards of practice for food services safety as evidenced by hot food temperatures that tested at less than 135° Fahrenheit (F) during a food tray assessment on April 12, 2022. The findings include: Hot foods temperatures were inconsistent during a test tray assessment on April 12, 2022. Hot foods from the regular diet, such as fried fish (pollock), green beans, and rice, tested under 135° Fahrenheit (F), while mechanical and pureed foods were above required temperature.	F 812	F812 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No resident was affected by this deficient practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected by this practice. Food services director will conduct rounds every two hours in the kitchen to ensure that food is distributed in accordance with professional standards of practice. that the residents get their food within the standard temperature . Any issues found will be corrected by 8/24/22.	8/24/22

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F 812	Continued From page 312 Fried Fish (regular diet) = 132° F White Rice (regular diet) = 132° F Green Beans (regular diet)) = 129° F Mixed Vegetables (mechanical) = 138° F Fried Fish (mechanical) = 147° F White rice (mechanical) = 142° F Fried Fish (puree) = 150° F Mixed Vegetables (puree) = 148° F Mashed Potatoes = 150° F These findings were acknowledged by Employee #15, during a face-to-face interview on April 12, 2022, at 3:45 PM.	F 812	F 812 MEASURES TO PREVENT RECURRENCE. In-service will be provided by Staff Educator/ Designee to the dietary staff on the importance to ensure that food is served and distributed in accordance with professional standards by 8/24/22. Food Services Director will ensure that his staff members serve and distribute food in accordance with professional standards of practice for food services. Any issues found will be corrected by 8/24/22. Dietician and Nutritionist will ensure that the food served to the residents are in accordance with professional standards of practice for food services. Any issues will be corrected by 8/24/22. Food service director will ensure pallets temperature is up to standard to enable the food to stay warm. Any issues found will be corrected 8/24/22. Food services director will conduct food temperature test on the units to confirm that the food temperature of hot food is at 140 degrees per food service standards. Any issues found will be corrected by 8/24/22 MONITORING CORRECTIVE ACTION: Director of food services will monitor and ensure that food is served and distributed in accordance with food standards. This audit will take place weekly x4, then monthly x3. Findings will be corrected and reported to QAPI Committee.	8/24/22
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, Administration failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as evidenced by failure to ensure that: staff implemented measures to prevent resident-to-resident abuse and altercations for six (6) residents; adequate supervision was provided to one (1) resident who sustain a dislocated hip of unknown origin; to adequately supervise one (1) resident who sustained a fall with injury; ensure the appropriate respiratory	F 835		

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F 835	Continued From page 313 medical supplies were on hand for care and treatment, and to ensure staff were trained on how to care for two (2) residents with a laryngectomies. The census on the first day of survey was 255. The findings include: 1. In the area of 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, Administration failed to ensure residents were free from abuse (willful infliction of injury) and neglect as evidenced by: failure to prevent the willful infliction of serious injury of Resident #404 by Resident #82; failure to implement person center care measures for Resident #151 who had incidences of aggressive behavior towards one (1) resident and willful infliction of injury to one (1) resident; and failed to ensure staff received training to provide person centered care to one (1) resident post hip replacement. Subsequently, the resident sustained a dislocated hip. During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings. Cross reference 42 CFR§ 483.12, F600, Freedom from Abuse, Neglect, and Exploitation 2. In the area of 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices, the Administration failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents as evidenced by: resident-to-resident altercation resulting in serious injury to one (1) resident; resident-to-resident altercation resulting in harm to one (1) resident; failure to supervise one (1)	F 835	F 835 starts here: CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #82 was placed on 1:1 monitoring for aggressive behavior. Resident was taken into custody by DC police on 7/20/22 Resident #151 is on 1:1continous monitoring for aggressive behavior. Resident #409 is discharge to another facility on 9/28/2021. Resident #56 obtained hematoma on the left side of the forehead on 4/7/2022. RP and MD were notified. X-ray was done without a fracture. Resident #183 was assessed from head to toe. No bruises, redness or swelling found. RP and MD notified. Resident #3 is no longer in the facility and was sent to the hospital 3/29/2022 and did not return to the facility. Resident #304 was assessed for respiratory distress secondary to lack of equipment on 4/26/22, resident suffered no negative outcome. All respiratory equipment will be handy and cleaned by 8/24/22. Administration will be provided coaching and training on: (1) Proper implementation and compliance of facility processes including conducting daily clinical grand rounds to ensure that the immediate clinical and physical needs of the residents are being met. (2) Properly obtaining clinical validation reports from the clinical and non clinical team to address issues in a timely manner, (3) How to properly conduct and review all allegations of abuse , incidents and accidents by the Rytes Compliance Consulting Group to ensure that the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Training and coaching will be completed by 8/242022.	8/24/22

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F 835	Continued From page 314 resident while seated in a wheelchair outside in front of the facility and subsequently sustained a fall resulting in harm; failed to implement resident-centered interventions (assistive devices) for one (1) resident status post left hip replacement, who subsequently sustained a dislocated hip of unknown origin; failed to secure one (1) residents wheelchair during a van transport; failed to implement care plan interventions to help prevent one (1) resident with a history of falls. During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings. Cross Reference 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices 3. In the area of 42 CFR 483.25(i), F695 Respiratory Care, the Administration failed to ensure Resident #3's airway (stoma) was not occluded by a medical device (Heat Moisture Exchanger (HME) subsequently, causing the resident to be transferred to the Emergency Room (ER) for dislodgment;(2) keep a supply of respiratory medical equipment in the facility that was necessary to care for and treat Resident #3's laryngectomy (lary-tube) and stoma (airway) subsequently, the resident had to be transferred to the ER for a replacement; (3) Obtain/provide Resident #3 with HMEs; (4) failed to change and clean respiratory equipment in accordance with the physician's orders; failed to obtain an order for the use of a "button" (HME) for Tracheostomy Status for one (1) resident. Residents' #3 and Resident #304. Cross Reference 42 CFR 483.25(i), F695	F 835	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. Administration will conduct house wide audit to ensure that facility is using its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of the residents, to ensure that no resident is exposed to abuse and neglect, that residents are provided help with assistive devices, that residents are supervised at the front of the building and that the employees are adequately supervising the residents to prevent altercations, that residents with respiratory diagnosis have their supplies always and the van has all safety components. This audit will be reviewed by the Regional Director of Operations/Regional Corporate Compliance. Any issues found will be corrected by 8/24/22.	8/24/22

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F 835	Continued From page 315 Respiratory Care During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings.	F 835	MEASURES TO PREVENT RECURRENCE: Administration will ensure that Clinical Grand Rounds are conducted daily by the IDT (clinical and non-clinical). Participation of the Clinical Grand Rounds will be tracked and trended through the clinical validation report and the Clinical Grand Round findings obtained during the stand down meeting at end of day. This corrected practice will be in place no later than 8/24/2022.	8/24/22
F 837 SS=E	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, Governing body failed to ensure that established and implemented policies regarding the management and operation of the facility were followed and action plans were developed and implemented to: prevent resident-to-resident abuse and altercations for six (6) residents; ensure adequate supervision was provided to one (1) resident who sustain a dislocated hip of unknown origin; adequately supervise one (1) resident who sustained a fall with injury; ensure the appropriate respiratory medical supplies were on hand for care and treatment; ensure staff were	F 837	Administration will ensure that abuse investigations and documentations are reviewed and audited by the administrator/DON daily. This corrected practice will be in place no later than 8/21/2022. Administration will ensure that end of day stand down meetings are conducted, and clinical validation reports are submitted daily by the IDT to administration. This corrected practice will be in place no later than 8/24/2022. In-service will be provided by Rytes Compliance Consulting Group to the administration on the importance of providing a person-centered care plan for the residents efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . Administration will follow up weekly to ensure compliance. Findings will be corrected by 8/24/22 In-service will be provided by the Rytes Compliance Consulting Group to the administration, department heads and licensed nursing staff to ensure that they implement written measures put in place to ensure patient safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by 8/24/22. Rytes Compliance Consulting Group will provide in-service to administration, department heads, licensed nursing staff, C N A, on what to do when a resident becomes aggressive, Administration will follow weekly to ensure compliance. Findings will be corrected by 8/24/22 The Regional Director of Operations and the Regional Compliance officer will ensure that the administrator is making sure that that morning rounds and validation are taking place daily. Findings will be corrected by 8/24/22	

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F 837	Continued From page 316 trained on how to care for two (2) residents with a laryngectomies; and to ensure the administrative staff maintained the integrity of an Incident/Accident Report (investigative report) for one (1) resident. The census on the first day of survey was 255. The findings include: 1. In the area of 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, Administration failed to ensure residents were free from abuse (willful infliction of injury) and neglect as evidenced by: failure to prevent the willful infliction of serious injury of Resident #404 by Resident #82; failure to implement person center care measures for Resident #151 who had incidences of aggressive behavior towards one (1) resident and willful infliction of injury to one (1) resident; and failed to ensure staff received training to provide person centered care to one (1) resident post hip replacement. Subsequently, the resident sustained a dislocated hip. During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings. Cross reference 42 CFR§ 483.12, F600, Freedom from Abuse, Neglect, and Exploitation 2. In the area of 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices, the Administration failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents as evidenced by: resident-to-resident altercation resulting in serious injury to one (1) resident; resident-to-resident altercation resulting in harm	F 837	Administration will ensure that staff educator provide in service to licensed nurses, C N A 's and restorative staff on how to take care of residents with hip dislocation to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident Administration will conduct rounds daily to ensure that the residents are monitored every shift for safety. Any issues found will be corrected by 8/24/22. Administration will ensure that the residents with respiratory diagnosis have supply are at bedside and in central supply for their respiratory needs to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident In-service will be provided by Rytes Compliance Consulting Group to administration, department heads, licensed nurses and C N A 's on the importance of ensuring supervision for residents with assistive devices to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Administration will ensure compliance weekly. Administration will ensure that Charge nurses are ensuring that residents with aggressive behavior are placed on -on- one until evaluated by psychiatrist. Findings will be addressed by 8/24/22 Administration will ensure that Unit manager are making ensure that resident exhibiting aggressive behavior towards another resident will be relocated to another unit. Admin/DON/Designee will ensure compliance weekly. Findings will be addressed by 8/24/22. Administration will ensure compliance weekly by auditing inventory sheets for supplies. Respiratory therapist will ensure that respiratory supplies are available. Findings will be corrected by 8/24/22 Administration will ensure weekly that respiratory therapist and charge nurses are cleaning respiratory medical equipment, that the nurses are taking orders to provide care for residents with respiratory diagnosis and that the orders are implemented per the physicians' orders, Administration will ensure weekly that licensed nurses are implementing care plan interventions to help prevent residents with multiple falls. Findings will be addressed by 8/24/22.	8/24/22

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F 837	Continued From page 317 to one (1) resident; failure to supervise one (1) resident while seated in a wheelchair outside in front of the facility and subsequently sustained a fall resulting in harm; failed to implement resident-centered interventions (assistive devices) for one (1) resident status post left hip replacement, who subsequently sustained a dislocated hip of unknown origin; failed to secure one (1) residents wheelchair during a van transport; failed to implement care plan interventions to help prevent one (1) resident with a history of falls. During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings. Cross Reference 42 CFR 483.25(d)(1)(2), F689 Free of Accident Hazards/Supervision/Devices 3. In the area of 42 CFR 483.25(i), F695 Respiratory Care, the Administration failed to ensure Resident #3's airway (stoma) was not occluded by a medical device (Heat Moisture Exchanger (HME) subsequently, causing the resident to be transferred to the Emergency Room (ER) for dislodgment;(2) keep a supply of respiratory medical equipment in the facility that was necessary to care for and treat Resident #3's laryngectomy (lary-tube) and stoma (airway) subsequently, the resident had to be transferred to the ER for a replacement; (3) Obtain/provide Resident #3 with HMEs; (4) failed to change and clean respiratory equipment in accordance with the physician's orders; failed to obtain an order for the use of a "button" (HME) for Tracheostomy Status for one (1) resident. Residents' #3 and Resident #304.	F 837	MONITORING CORRECTIVE ACTION Administration will conduct house wide audit to ensure that residents with behavior problems are supervised and monitored every shift. This audit will be conducted weekly x3 and monthly x4 . Findings will be corrected and reported to QAPI Committee	8/24/22

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	095019	A. BUILDING _____ B. WING _____	C 04/20/2022

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F 837	Continued From page 318 Cross Reference 42 CFR 483.25(i), F695 Respiratory Care During the face-to-face interview on 04/20/2022 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings. 4. In the areas of 42 CFR 483.70(i) Medical records and 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident ...the governing body failed to ensure a resident's record contained accurate information as evidenced by failure to: accurately record information on a Treatment administration record for one (1) resident; maintain the integrity of an "Incident/Accident Report" related to a resident-to-resident altercation resulting in serious injury to the resident; and ensure resident's medical record were accurately documented for three (3) residents. Residents' #3, #126, #164, #404, and #408. Cross Reference 42 CFR 483.70 (i) Medical records and 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident ... F842 During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings.	F 837	F837 starts here: CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #82 was placed on 1:1 monitoring for aggressive behavior. Resident was taken into custody by DC police on 7/20/22 Resident #151 is on 1:1continous monitoring for aggressive behavior. Resident #409 is discharge to another facility on 9/28/2021. Resident #56 obtained hematoma on the left side of the forehead on 4/7/2022. RP and MD were notified. X-ray was done without a fracture. Additional staff was hired to supervise residents outside. Resident #183 was assessed from head to toe. No bruises, redness or swelling found. RP and MD notified. Resident #3 is no longer in the facility and was sent to the hospital 3/29/2022 and did not return to the facility. Resident #304 was assessed for respiratory distress secondary to lack of equipment on 4/26/22, resident suffered no negative outcome. All respiratory equipment will be at bedside and in central supply by 8/24/22. Education to be provided by the Rytes Compliance Consulting Group to the Governing Body on their duties and responsibilities and how to function properly as members of the Governing Body to ensure that established and implemented policies regarding the management and operation of the facility were followed and action plans were developed and implemented. Members of the Governing Body include but are not limited to: Regional Director of Operations, Regional Director of Compliance, DON,ADON, QA, Compliance Officer, and Staff Educator. This will be completed no later than 8/24/2022.	8/21/22
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what	F 838	Rytes Compliance Consulting Group to provide education to the Governing Body on proper implementation of established policies and procedures pertaining to (1) prevention of resident abuse, (2) physical safety and fall prevention, (3) ensuring staff clinical competencies, (4) maintaining integrity of medical records and incident reporting, and (5) maintaining adequate medical supplies to ensure that the management and operation of the facility were followed, and action plans are developed	

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F 838	Continued From page 319 resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;	F 838	F 837 MEASURES TO PREVENT RECURRENCE: The governing body will ensure that established and implemented policies regarding the management and operation of the facility are followed and plans are developed and implemented for the smooth running of the facility. Any issues found will be corrected by 8/24/22. The governing body will validate that the Administration is monitoring the implementation of established policies to ensure the safety of the residents. Any issues found will be corrected by 8/24/22. The governing body will ensure that the administration, department heads and nursing staff are implementing nursing policies and procedures and are keeping the residents safe. Any issues found will be corrected by 8/24/22. In-service provided by Rytes Compliance Consulting Group on corporate compliance, ethics, competency and QAPI implementation to the governing body, administrator and department heads on 7/14/22 The governing body will ensure that the administration, department heads, director of quality assurance and the nursing staff are ensuring that the implementation of policies and procedures are put in place to ensure the safety of the residents. Any issues found will be corrected by 8/24/22 The governing body will attend quality assurance meeting and at-risk meeting to ensure that DON, Department heads, QA Director, ADON and unit managers are auditing incident reports to address residents with aggressive behavior, ensure the team understands how to monitor and supervised residents with aggressive and wandering behaviors. Findings will be corrected by 8/24/22 The governing body will audit the Director of Quality Assurance to ensure that all accidents/ incidents are captured and addressed in a timely manner weekly. Any issues found will be corrected by 8/24/22	8/24/22

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F 838	Continued From page 320 (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to update the Facility Assessment to reflect the facility's current operations. The resident census on the first day of survey was 255. The findings included: The resident alpha census on the first day of survey, 03/26/22, revealed that 255 residents were in the facility. The facility has a licensed bed capacity of 296 residents. Review of the "Facility Assessment" document last updated 02/24/22 revealed the following: Part 2: Services and Care We Offer Based on our Resident Needs Page 5 Management of Medical Conditions	F 838	The governing body must ensure that the facility has adequate supplies to meet that residents need. Inventory of supplies must be reviewed on a weekly basis. Any issues found will be corrected by 8/24/22. The governing body designee will follow up with the DON to ensure that respiratory equipment is cleaned at all times by the respiratory therapist/ designee. The Administration will validate findings on a weekly basis. Any issues found will be corrected by 8/9/22. The governing body will ensure that residents are supervised for safety, especially those with frequent falls and residents with hip replacement weekly. Findings will be corrected by 8/24/22 The governing body will follow up with the administration to ensure that residents using wheelchair are assessed for wheelchair managements weekly .Findings will be addressed , documented and their plan of care will be updated by 8/24/22 The governing body will ensure that the Administration is following up to ensure that licensed nurses and C N A's know how to provide care for residents with hip replacements and that injury of unknown origin are accurately investigated. Findings will be addressed by 8/24/22 Rytes Compliance Consulting Group will provide in service to the Administration on the importance of maintaining the integrity of incident reports and facility records are maintained. The governing body will ensure the licensed nursing staff are adequately trained on how to take care of patients with laryngectomies. The respiratory therapist will be responsible for the training and will ensure compliance by 8/24/2022.	8/24/22

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F 838	Continued From page 321 stipulated, "The DON (Director of Nursing) with the Admissions department reviews all admission referrals to ensure that resources are available to accommodate all cases. If additional resources are needed in the case of complex referrals, in-service are conducted for nursing staff to meet the particular needs of the referral prior to admission." However, through observation3, record review staff and family interviews, it was determined that facility staff failed to maintain or have in the facility Resident #3's medical equipment, a Lary Tube (used to maintain the opening of the tracheostoma) subsequently, the resident had to be transferred to the ER for a replacement. Under, "Other special care needs" - the facility lists "ventilator care" as a service offered. During a face-to-face interview with Employee #2 and Employee #5 on 04/20/22 at approximately 11:15 AM (during the Quality Assurance Interview) they stated the facility does not accept resident on ventilators.	F 838	Governing body will ensure Training is provided by staff educator/ Designee to administration, department heads, licensed nurses and C N A on how to care for residents with hip replacements, how to investigate injury of unknown origin, how to supervise residents with aggressive behavior, patient safety out of the building. Governing body will conduct rounds to ensure that the respiratory therapist is following up with residents with stoma to ensure there are no occlusions. Findings will be corrected by 8/24/22. Governing body will ensure that the facility has a van that contains safety components, and that the driver is educated on resident safety while riding the van. MONITORING CORRECTIVE ACTION The governing body will conduct rounds to ensure that residents are supervised and monitored, that the clinical team are investigating injury of unknown origin correctly and that licensed nursed are providing correct care to residents with Lary tube, that residents are safe in and out of the building, that facility reports maintain its integrity, that the facility has adequate supply to take care of the residents needs. This audit will take place weekly x4, then monthly x3. Findings will be corrected and reported to QAPI Committee.	
F 842 SS=E	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.	F 842		

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F 842	Continued From page 322 §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 §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 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	F 842	F838 STARTS HERE: The facility's assessment has been revised to reflect the facility's current operations. Resident capacity has been updated, types of diseases, physical and cognitive ability of the residents, staff competencies. Environmental status and availability of supplies. Van for transportation with safety features. Admission coordinator/ DON/Designee will review admission referrals . The facility administrator will ensure all medical and non-medical needs of the residents are met .	8/24/22

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F 842	Continued From page 323 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 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for five (5) of 105 sampled residents, the facility's staff failed to ensure a resident's record contained accurate information as evidenced by failure to: accurately record information on a Treatment administration record for one (1) resident; maintain the integrity of an "Incident/Accident Report" related to a resident-to-resident altercation resulting in serious injury to the resident; and ensure resident's medical record were accurately documented for three (3) residents. Residents' #3, #126, #164, #404, and #408. The findings include: Review of the facility policy entitled, "Clinical Documentation/Record" dated 03/2022 revealed, "It is the policy of [Facility Name] to ensure accurate documentation of important elements contributing tote high quality care of our residents ... Clinical documentation is required to record pertinent facts, findings and observations about	F 842	F842 STARTS HERE CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENT: Resident #3 was sent to the hospital 3/29/22 and did not return to the facility. Resident #126 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22.Unit manager will ensure resident is properly transferred from wheelchair to bed, two persons assist with hoyer lift.	8/24/22

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F 842	Continued From page 324 resident's health ..." 1. The facility staff failed to ensure Resident #3's Treatment Administration Record for 01/08/22 to 02/07/22 contained accurate information. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of a physician's order dated 12/02/21 [physician order] instructed stated staff to, "Change HME (Heat Moisture Exchanger) daily Day shift." Review of Treatment Administration Records from 01/08/22 to 02/07/22 showed that the facility's nurses initialed that they changed Resident #3's HME daily on dayshift. However, during a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that Resident #3 did not have HMEs to connect to his lary-tube from 01/08/22 to 02/07/22. When asked why it took so long for Resident #3 to get HMEs, Employee #31 said, "I did not know the size of the resident's lary-tube. And the HMEs we had in house was not compatible with the lary-tube his family provided on 01/08/22." 2. Facility staff failed to accurately document the findings of Resident #126's incident investigation on the report. Review of the FRI (Facility Reported Incident) dated 12/27/21 documented "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched	F 842	Resident #164 was assessed by unit manager on 4/26/22 to ensure that blood pressure was taken on the correct arm. Resident suffered no negative outcome. Resident # 404 went to the hospital and did not return Resident #404 sent to ER and did not return to the facility. IDENTIFICATION OTHERS WITH THE POTENTIAL TO BE AFFECTED All residents in the facility have the potential to be affected by this practice. House wide audit will be conduct by DON/ Designee to ensure that all residents treatment record contain accurate information, that there is sufficient documentation on all incident reports, that the nurses are taking blood pressure for residents on dialysis on the correct arm and that documentation is done for residents who are in the facility. Any issues found will be corrected BY 8/24/22	8/24/22

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F 842	Continued From page 325 against the 1/4 side rail; resident sustained a laceration on the upper lateral right leg; resident scratched her right leg at the edge of the 1/4 side rail. Writer was made aware of the incident; writer assessed the wound." Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Heart Failure Unspecified, Presence of Right Artificial Knee Joint, Chronic Kidney Disease, Stage 4 (Severe), and Other Lack of Coordination. Review of the Admission Minimum Data Set (MDS) dated 11/17/21, revealed that the facility staff coded the following: In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "11", indicating moderately impaired cognition. In section G (Functional Status): Transfer "Extensive assistance" requiring "Two-person physical assist" Review of the Facility Reported Incident that was submitted to the Department of Health on 12/23/21 at 6:47 PM showed, " ...During a transfer from wheelchair to bed by two staff residents suddenly sway her leg scratched against the ¼ side rail ...writer was made aware of incident; writer assessed the wound ..." Review of the nursing progress note dated 12/23/2021 at 11:50 AM documented, "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the ¼ side rail ..." Review of the facility's investigation of the incident	F 842	MEASURES TO PREVENT RECURRENCE. In service will be provided to all licensed nursing staff by Staff Educator/ Designee on the importance of ensuring that information in the resident's record is accurate, that documentations on incident report is completed accurately and that blood pressure is taken on the arm where the dialysis access site is not present by 8/24/22. In -service will be provided to C N A's to take blood pressure on the non-dialysis arm by the Staff Development or designee by 8/24/22. ADON/ Designee will conduct audit to ensure that nurses are documenting accurately on the arm on which blood pressure was taken for dialysis residents. Any issues found will be corrected by 8/24/22 Supervisors / Designee will ensure that licensed nurses are completing incident reports in a timely manner. Any issues found will be corrected by 8/21422. Unit managers will ensure that the nurses do not document on a resident who is out of the facility. Any issues found will be corrected by 8/24/22.	8/24/22

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F 842	Continued From page 326 revealed a handwritten statement by the certified nurse aide who was involved in the incident dated 12/22/2021 at 5:15 PM showed, "On 12/22/21, I floated to 3N to work at approximately 5:15 PM [Resident #126] asked me to put her in bed. I took her to her room in transferring her I notice the leg was bleeding. When I got her on the bed, I called the nurse to come and have a look at it." The handwritten nurse's statement which was signed and dated 12/22/21 was reviewed and it lacked any mention of any additional staff being interviewed regarding the incident. During a face-to-face interview conducted on 04/20/2022 at 10:45 AM with Employee #58 (Certified Nurse Aide) stated "It was just me who transferred her [Resident #126] to the bed. Nobody was there only me." Employee # 58 was responding to questions about the incident with Resident #126 that documented on 12/23/2021 in which staff was transferring resident from the wheelchair to the bed. During a face-to-face interview conducted on 04/20/2022 at 1:38 PM with Employee #7 (Clinical Coordinator) Employee #7 acknowledged the findings. 3. Facility staff failed to accurately document the site where they obtained Resident #164's blood pressure. Resident #164 was admitted to the facility on 07/26/2016 with multiple diagnoses that included: End Stage Renal Disease, Type 2 Diabetes Mellitus, and Hyperlipidemia. Review of Resident #164's medical record	F 842	MEASURES TO PREVENT RECURRENCE CONT. Unit managers/ supervisors will ensure weekly that the charge nurses are documenting accurately in residents' medical records. Findings will be corrected by 8/24//22 Administrator/ DON/ADON will ensure weekly that the integrity of resident's incident report is maintained. Findings will be corrected by 8/24/22. Unit manager will ensure that resident # 126's record contain accurate information., and that investigations on incidents are completed Findings will be corrected by 8/24/22 Unit manager will ensure weekly that charge nurses are documenting the correct arm on which blood pressure is taken. For resident #164. Findings will be corrected by 8/24/22 ADON/Designee will ensure weekly that no one is documenting on a resident who is out of the facility. Findings will be corrected by 8/24/22	8/24/22

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F 842	Continued From page 327 revealed the following: 03/04/2022 [Quarterly MDS], facility staff coded a BIMS summary score of "15", indicating intact cognitive response and "yes" to dialysis in Section O (Special Treatments, Procedures, and Programs). 04/07/2022 [Physician's Order] "Assess dialysis AV (arteriovenous) graft site on left upper arm for bleeding, redness, tenderness, and swelling every shift, (No B/P (blood pressure) and no blood draws on this arm) every shift" 03/18/2022 (Revision date) [Care Plan] "[Resident #164] has Left arm site used for dialysis ...Do not take blood pressure or blood specimens from left arm ..." Review of the vital signs documentation from 03/18/22 to 04/10/22 showed that facility documented: 03/18/22 at 8:05 PM 136/87 mmHg (millimeters of mercury) Lying l/arm (left arm) 03/22/22 at 9:39 PM 130/74 mmHg Lying l/arm 03/25/22 at 11:11 PM 128/74 mmHg Lying l/arm 03/26/22 at 8:40 PM 128/72 mmHg Lying l/arm 03/27/22 at 11:29 AM 139/74 mmHg Lying l/arm 03/27/22 at 10:41 PM 128/72 mmHg Lying l/arm 03/28/22 at 11:38 PM 130/74 mmHg Lying l/arm 03/31/22 at 6:41 PM 128/74 mmHg Lying l/arm 04/09/22 at 1:51 PM 138/76 mmHg Lying l/arm 04/09/22 at 7:35 PM 128/72 mmHg Lying l/arm 04/10/22 at 11:50 AM 120/71 mmHg Lying l/arm The evidence showed that facility staff failed to accurately document the site where they were obtaining Resident #164's blood pressure.	F 842	MONITORING CORRECTIVE ACTIONS DON/Designee will conduct house wide audit to ensure that residents treatment record (TAR) contain accurate information, that incidents/accidents are investigated, that blood pressure is taken on the nondialysis arm for dialysis residents and that nurses are not documenting on residents who are not in the facility. This audit will be carried out weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI committee	8/24/22

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During a face-to-face interview conducted on 04/20/22 at 10:36 AM, Employee #2 (Director of Nursing) acknowledged the finding ad stated, "This is an identified issue and a PIP (performance improvement plan) is in place to address the issues of documentation."

4.Facility staff documented completing tasks on Resident #404 while he was out of the facility (hospitalized) and recreated an "Incident/Accident Report" related to a resident-to-resident altercation resulting in serious injury to the resident.

A. Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, "...The charge nurse observed [Resident 404] sitting on the floor besides his roommate's ... bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face ... [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell ..."

Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack.

Review of Resident #404's medical record showed the following:

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09/29/21 [Physician's Order] "Hourly elopement/wandering monitoring and location. every hour..."

02/21/22 [Treatment Administration Record] revealed a check mark and licensed staff initials for the evening shift (3:00 PM- 11:00 PM) in the sections, "Nurse to complete full body skin evaluation on shower days ...on Monday ..."; "Check wonder guard functioning and placement on left ankle every shift, hours ..."; "Apply ... ointment to entire body ..."; "Assess skin around and behind ear and ear lobe for irritation ..."; "Monitor for sign of COVID- 19 ...", indicating that the task was completed.

The TAR further revealed that facility staff documented a temperature of "97.7" (degrees Fahrenheit) on 12/21/22 for the evening shift.

Continued review showed that from 02/21/22 at 4:00 PM to 02/26/22 at 3:00 AM, facility staff documented 14 times that Resident #404 was "In room (IRM)" in the section, "Hourly elopement/wandering monitoring and location. every hour..."

02/21/22 at 4:57 AM [Nursing Supervisor Progress Note] "... The Ambulance left with the Resident at 3:15 AM to [Hospital Name]. They were handed over the Resident's face sheet, order summary, Code status, Recent Physical, labs, and order to transfer."

02/21/22 at 1:43 PM [Nurse's Progress Note] "A call was paced to [Hospital Name] to know about the status of the resident in the ER, spoke with nurse [Registered Nurse's Name] who stated resident is critically ill, he has been intubated and

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about to be transferred to ICU (intensive care unit). RP (representative)... made aware"

During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #7 (Clinical Coordinator) acknowledged the findings and made no further comments.

B. Facility staff failed to maintain the integrity of an "Incident/Accident Report" related to a resident-to-resident altercation resulting in serious injury to the resident.

During a face-to-face interview conducted on 03/30/22 at 12:15 PM, Employee #1 (Administrator) provided the survey team with a copy of the facility's investigation documents of the resident-to-resident altercation. The documents revealed an "Incident/Accident Report" with Resident #404's name dated "2/22/22" that showed the following: An anatomical depiction with no markings to reflect that Resident #404 had no injuries, for "type of injury", "swelling" was checked and the words "left face" written next to it, "no" in the section asking if person taken to the hospital, name and signature of Employee #7 (Clinical Coordinator) as the "person preparing report", name and signature of Employee #6 (Administrator in Training) in the section, "Director of Nursing", the name and signature of Employee #1 in the section "Administrator". The documents also revealed written statements from Employee's #25 (Registered Nurse), #26 (CNA), #27 (CNA), #28 (Nursing Supervisor) and #29 (CNA).

An email correspondence was received by the survey team from Employee #1 on 03/30/22 at 8:53 PM. This correspondence revealed a

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second copy of the facility's investigation documents of the resident-to-resident altercation. This document was an "Incident/Accident Report" with Resident #404's name on it dated "2/21/22" that revealed the following: An anatomical depiction with markings to showed areas of injury on the right side of the face, for "type of injury", "Other (specify)" had "bleeding from the mouth and left ear" written next to it, "yes" in the section asking if person taken to the hospital and [Hospital's Name] next to it, the name and signature of Employee #7 (Clinical Coordinator) as the "person preparing report", name and signature of "Director of Nursing" was blank, the name and signature of Employee #1 in the section "Administrator". The documents also revealed written statements from Employee's #25 (Registered Nurse), #28 (Nursing Supervisor), #29 (CNA) and a typed statement with the name and signature of Resident #82, absent of date and time.

During a face-to-face interview conducted on 03/31/22 at 3:30 PM, Employee #1, was asked why there are two versions of the facility's investigation report. She stated, "I couldn't find it (the original) on Saturday (03/26/22). I redid the report and had the employees rewrite their statements." Employee #1 also stated that she completed the incident/accident report form with dated 02/22/22, wrote in and signed Employee #7's name and signature on the report because he was out of the country at the time. Employee #1 continued to say, "Employee #6 (Administrator in Training) found the original documents (dated 2/21/22) in the shred box and those were the documents that were emailed [on 03/30/22]."

During a face-to -face interview conducted on

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04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) Employee #7 was asked about the incident/accident report that was provided to the survey team on 03/30/22 as part of the facility's investigation documents. Employee #7 stated that he completed the incident/accident form and submitted it to Employee #1 (Administrator) on 02/21/22. When showed a copy of the "Incident/Accident Report" document dated 02/22/22 with his name and signature, Employee #7 stated, "That is not my writing. This is not the incident report that I filled out and provided to the Administrator."

During a face-to-face interview conducted on 04/11/22 at 5:49 PM with Employee #6, she stated, "I was not part of the original incident report. I got involved in the part of the process at the point when we couldn't find it (original investigation documents). The original incident report was done by [Employee #7]. When we couldn't find it, I filled out the incident/accident report forms [to include writing in Employee #7's name on the signature line]. That's my handwriting. She [Employee #1] just signed it [the form on the administrator signature line]."

During a face-to-face interview conducted on 04/11/22 at 5:49 PM, Employee #6 (Administrator in Training) acknowledged and admitted to recreating the "Incident/Accident Report" related to resident-to-resident altercation resulting in serious injury to Resident #404.

5. Facility staff inaccurately documented to doing assessments on Resident #408 who has hospitalized.

Review of the FRI dated 02/22/22 documented,

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"...Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP (Nurse Practitioner) ... X-ray report received this morning with impression of Acute fracture of the left distal femur, Acute hairline fracture of the right lateral femoral condyle ... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident
had reported fallen to anyone..."

Resident #408 was admitted to the facility on 05/25/21 with multiple diagnoses that included: Hemiplegia and Hemiparesis, Hypocalcemia, Muscle Weakness and Lack of Coordination.

Review of Resident #408's medical record revealed the following:

01/04/22 [Quarterly MDS], facility staff coded the following: a BIMS summary score "04", indicating severe cognitive impairment.

02/17/22 at 11:29 AM [Social Work Progress Note] "[Resident #408] was transferred to [Hospital Name]..."

02/17/2022 12:05 PM [Nurses Note] " ... Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP ... NP ordered X-rays of bilateral knees. X-ray report received this morning with impression of acute fracture of the left distal femur, acute hairline fracture of the right lateral femoral condyle ... [Physician's Name] notified and she gave order to send resident to the ER (emergency room) for 2nd opinion ..."

02/17/2022 at 5:02 PM [Social Work Progress

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F 842	Continued From page 334 Note] "Resident was sent to the hospital. The 6-108 was completed and forwarded to Ombudsman ..." Review of Resident #408's electronic medical record revealed that despite the resident being hospitalized, facility documented to completing the following resident assessments: 02/27/2022 at 9:14 AM Safe Smoker 02/27/2022 at 10:20 AM Dental/Oral 02/28/2022 at 12:17 PM Elopement Risk 02/28/2022 at 12:18 PM Use of Side Rail(s) 02/28/2022 at 12:19 Bladder and Bowel. During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #7 (Clinical Coordinator) acknowledged the findings and stated, "The assessments automatically pop up if they are still in the system even though the resident maybe out of the facility."	F 842		8/24/22
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to maintain and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems as evidenced by failing to ensure that they developed plans of action to	F 867		

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F 867	Continued From page 335 identify quality deficiencies. The resident census during the survey was 255. The findings include: Facility staff failed to develop and implement appropriate plans of action to correct identified quality deficiencies as follows: Under §483.12, F600 Freedom from Abuse, Neglect, and Exploitation Under §483.25(d)(2), F689 adequate supervision and assistance devices to prevent accidents Under § 483.25(i), F695 Respiratory care Under §483.25(k) F697 Pain Management During a face-to-face interview was conducted with Employee #2 and Employee #5 on 04/20/22 at approximately 12:00 PM, at the time of the Quality Assessment and Assurance (QAA) interview. They were asked if the facility identified resident-to-resident abuse and altercations, resident behaviors, residents wandering, activities of daily living (ADL) care, Respiratory/Tracheostomy Care and Pain management, in their review and if so how was each area addressed? The stated: [Resident-to-resident abuse and resident behaviors]- In QA we don't address behaviors. We review them in the "At Risk Meeting", its only escalated to QA when it's a systemic problem. We have a safety committee meeting, we look at the hazards for month, the interventions, and what was the root cause. The resident-to-resident altercations are discussed at the "At risk meeting", it's only discussed at QA when its systemic or widespread. Employee #2	F 867	F 867 QAPI / QAA will ensure that the facility staff maintain and implement an effective comprehensive quality assurance and performance program that will show that areas of deficiencies are adequately addressed. Any issues found will be corrected by 8/2422. QA committee will ensure that the staff are implementing plans that are put in place to address deficiencies. Any issues found will be corrected by 8/24/22. DON will ensure that the interdisciplinary team discuss residents who are at risk for a decline are discussed during the standup meeting. Any issues found will be corrected by 8/24/22. DON / Designee will ensure that all incidents/ accidents are discussed during the morning meetings and to validate that the incident had been fully investigated. Any issues found will be corrected by 8/24/22. Charge nurses will monitor and supervise residents who wanders to ensure they are safe. Any issues found will be corrected by 8/24/22. Quality Assurance Director/ Designee will ensure that the facility is implementing policies and procedures to address residents with intrusive behavior during At Risk meetings. Any issues found will be corrected by 8/24/22. The safety committee(department heads, clinical team, MDS ,Activities staff and unit secretaries) will ensure that they address safety issues at length during the meetings to ensure that the.. residents are provided with everything that the residents need to remain safe. Any issues found will be addressed by 8/24/22	8/24/22

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F 867	Continued From page 336 further stated, "We do not discuss behaviors in QA we are supposed to discuss behaviors. We will be bringing behaviors to QA moving forward. We have not looked at residents who wander in QA. We look at ADLs. We do a weekly quality of life meeting, we discuss residents' functional performance (Showers, feeders) and issues with that are discussed at the "At Risk Meeting". Respiratory/Tracheostomy Care and Pain management is not discussed at QA. Following the physician orders is reviewed at the morning "Clinical Meeting". Through interview with Employee #2 and Employee #5 at the time of the QAA review, it was determined that Quality Assurance committed/facility staff failed to develop and implement action plans to correct identified quality deficiencies related to resident-to-resident abuse, resident behaviors, ADL care, respiratory/tracheostomy care and pain management.	F 867	All incident reports /accident reports will be reviewed by Unit managers, ADON'S and DON. Sign in sheets will be in place to show attendance of those who reviewed incidents and accident reports. Any issues found will be corrected by 8/24/22. Residents who wander will be monitored and supervised every shift for safety purposes. Any issues found will be corrected by 8/24//22.	8/24/22
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		

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F 880	Continued From page 337 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880	F 800 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #132 was assessed from head to toe on 4/26/22, resident suffered no negative out come.MD/RP notified on 4/26/22. Resident urine collection bag is in a privacy bag, snugly and appropriately strapped to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Residents with Foley residing in the facility have the potential to be affected by this practice. House wide audit will be conducted by Licensed nursing staff to ensure that residents with urine collection bags have a privacy bag and that the bag is not on the floor. Also, to ensure that all employees are using their PPE'S correctly while in patient care area. Any issues found will be corrected by 8/24/22.	8/24/22

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F 880	Continued From page 338 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to: (1) ensure Resident #132's urine collection bag was not resting on the floor and (2) maintain infection control and prevention practices to help prevent the development and transmission of communicable diseases and infections. The census on the first day of survey was 255. The findings include: 1. Facility staff failed to provide ensure Resident #132's urine collection bag was not resting on the floor. According to the Center for Disease Control (CDC) guidelines for prevention of catheter associated urinary tract infections (CAUTI) includes: "... Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor."	F 880	F 880 MEASURES TO PREVENT RECURRENCE: Training will be provided to all staff in the facility by Staff Educators / Designee to ensure that staff put on the correct PPE while in patient care area by 8/24/22 In- service will be provided by Staff Educator/ Designee on the importance to ensure that urine collection bag is not on the floor by 8/24/22. Unit Managers will conduct rounds on their units during their shift to ensure staff are using PPEs correctly. Any issues found will be corrected by 8/24/22. Charge nurses will conduct rounds during their shift to ensure urine collection bag is not on the floor. Any issues found will be corrected by 8/24//22. QA nurse/Designee will conduct random rounds weekly to ensure that employees are wearing their PPE's correctly and following infection control practices. Any issues found will be corrected by 8/24/22. Supervisors / Designee will conduct rounds weekly to ensure infection control practices are implemented as indicated. Any issues found will be corrected by 8/24/22. Unit manager will ensure that resident # 132's urinary collection bag is not on the floor and that it is in a privacy bag at all times.	8/24/22

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	095019	A. BUILDING _____ B. WING _____	C 04/20/2022

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F 880	Continued From page 339 (https://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf) On 04/07/22 at approximately 3: 45 PM, Resident #132 was observed resident lying in bed with his urine collection bag resting lying on the floor. Resident #132 was readmitted to the facility on 02/11/22 with diagnoses that included: Urinary Tract Infection, Alzheimer's, Dementia, Epilepsy and Muscle Weakness (Generalized). A review of the Quarterly Minimum Data Set (MDS) for dated 02/17/22 revealed that facility staff coded the following: In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score of "99," indicating severely impaired cognition. During a face-to-face interview on 04/07/22 at 3:48 PM, Employee #47 (Licensed Practicing Nurse/LPN), acknowledged that the catheter bag was on the floor and stated, "It is because his bed is in its lowest position. I attached it up high this morning. I will explain to my CNA (Certified Nurse's Aide) that the bag should not be on the floor." 2. Facility staff failed to wear the required PPE while in a resident care area on three (3) of three (3) occurrences. A. During tour of unit 4 south on 04/06/22 at 6:16 AM, Employee #29 (CNA) was observed less than 6 feet apart from a resident, providing ADL care and did not have on a face shield.	F 880	F 880 MONITORING CORRECTIVE ACTION: DON/ Designee will conduct house wide audit to ensure that employees are wearing their PPE's correctly and ensure that the bag for urine collection is not on the floor. This audit will take place weekly x3 , then monthly x4. Findings will be addressed immediately, and report presented to QAPI committee.	8/24/22

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F 880	Continued From page 340 During a face-to-face interview conducted at the time of the observation, Employee #29 acknowledged the finding and stated that she was aware of the facility's policy to wear face shields at all times in the facility. 32. Facility staff failed to wear PPE while in a resident care area. B. During a tour of unit 4 north on 04/06/22 at 6:21 AM, Employee #49 (CNA) was observed coming out of a resident's room wearing a face mask but did not have on a face shield. During a face-to-face interview conducted at the time of the observation, Employee #49 acknowledged that she knew the facility's PPE policy and stated, "I just took it off, and I needed a little air." C. Facility staff failed to wear a face shield when providing for Resident #55. On 04/06/22 at 6:10 AM, Employee #26 (Certified Nursing Assistant) was observed providing am care (bed bath) for Resident #55 without wearing a face shield. During a face-to-face interview on 04/06/22 at 6:20 AM, Employee #26 stated that the facility's protocol is to always wear a face shield. She just forgot to put it (face shield) on.	F 880		8/24//22
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F 883		

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F 883	Continued From page 341 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883	F 883 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 182 was assessed from head to toe on 4/26/22 by unit manager, resident in no apparent distress. MD/RP notified on 4/26/22. Resident suffered no negative outcome. Resident refused to take the pneumococcal vaccine. Risk versus benefits explained. Resident #603 was assessed from head to toe by unit manager on 4/26/22, resident suffered no negative outcome. Responsible party accepted that pneumococcal vaccine this was administered on 6/15/22. House wide audit in progress for pneumococcal vaccine administration. Any issues will be corrected by 8/9/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All resident eligible for to receive pneumococcal vaccine have the potential to be affected by this practice House wide audit is ongoing to identify resident that the facility staff did not ensure they have taken or at least offered to administer the pneumococcal vaccine. Any issues will be addressed by 8/24/22.	8/24/22

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F 883	Continued From page 342 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 105 sampled residents, facility staff failed to ensure that there was documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization, the administration or the refusal of or medical contraindications to the vaccine(s). Residents' #182 and #603. The findings include: Review of the policy entitled, "Pneumococcal Policy and Procedure" (not dated) documented, "It is the policy of [facility Name] to offer to all residents pneumococcal upon admission and administer in accordance with the recommendations of the Centers of Disease Control (CDC) and the facility Medical Director..." 1. Resident #182 was admitted to the facility on 05/07/21 with diagnoses that included Hypertension, Heart Failure, Type 1 Diabetes Mellitus and Anemia in Chronic Kidney Disease. According the Quarterly Minimum Data Set (MDS) dated 03/04/22, facility staff coded	F 883	F883 MEASURES TO PREVENT RECURRENCE. In- service will be provided to all Licensed nursing staff to ensure that they offer to administer pneumococcal vaccine at no cost to the resident upon admission and ongoing by 8/24/2022. Licensed clinical staff will ensure that they re-offer to administer pneumococcal vaccine to residents who refused and ensure proper documentation is in place. Any issues found will be addressed by 8/24/22. Review will be conducted by supervisors to ensure that the consent for pneumococcal vaccine is signed upon admission and that the contents of the consent is implemented. Any issues found will be addressed by 8/24/22. The pneumococcal consent form has been added to the admission package so assist responsible party to determine if they want their loved ones to take the vaccine or not. Any issues found will be corrected by 8/2142022. Resident #182 will be offered pneumococcal vaccine by 8/9/22 Resident #603 will be offered pneumococcal vaccine by 8/24/22	8/24/22

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F 883	Continued From page 343 Resident #182 with a Brief Interview for Mental Status (BIMS) score of "14", indicating intact cognitive response. Review of Resident #182's electronic and paper health record lacked documented evidence that facility staff provided information/education to the resident or their representative regarding the benefits and risks of the influenza and pneumococcal immunization or the refusal of the vaccine(s). 2. Resident #603 was admitted to the facility on 03/14/22 with diagnoses that included: Unspecified Fracture of Left Patella and Upper End of Right Humerus, Seizures and Anemia. According the Admission MDS dated 03/20/2022, in Section C (Cognitive Status), facility staff coded Resident #603 as "resident is rarely/never understood." Review of Resident #603's electronic and paper health record lacked documented evidence that facility staff provided information/education to the resident or their representative(s) regarding the benefits and risks of the influenza and pneumococcal immunization or the refusal of the vaccine(s). During a face-to-face interview conducted on 04/13/22 at 10:03 AM, Employee #5 (Infection Preventionist) acknowledged the findings for Resident #182 and #603 and stated, "Vaccine administration consent or refusal is documented in Point Click Care (PCC). I will look and see if I can find it." It should be noted that Employee #5 was not able	F 883	F 883 MONITORING CORRECTIVE ACTION: DON/Designee will conduct house wide audit to ensure that pneumococcal status for each resident is documented. This audit will take place weekly x3, then monthly. Findings will be addressed and reported to QAPI Committee	8/24/22

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F 883	Continued From page 344 provide the survey team with any documentation for Residents' #182 or #603 vaccine(s) education, consent or refusal.	F 883		8/24/22