STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted at Forest Hills of DC on the following dates: February 17- 18, 2022 and February 22-25, 2022. Survey activities consisted of a review of 26 sampled residents. The facility's census during the survey was 45. The following complaint was investigated during this survey: DC00010523. The following facility reported incidences were investigated during this survey: DC00010109, DC00010124, DC00010123, DC00010121, DC00010144, DC00010168, DC00010219, DC00010222, DC00010262, DC00010309, DC00010320, DC00010344, DC00010409, DC00010423, DC00010507, DC00010523, DC00010521, and DC00010535. 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. 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 ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure	F 000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — 5/25/2022

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DERCIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

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 volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 568 SS=F	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the	F 568	1. Assisted Living residents TF1, TF2, TF3 were identified on the Trial Balance. The Chief Financial Officer (CFO) communicated to the bank to create separate accounts for skilled residents and assisted living residents. 2. The CFO or designee shall review accounting records of the skilled and Assisted Living residents to ensure resident funds are not commingled with the funds of any other person other than another resident. The bank process for this transaction will take a minimum of 6- 8 weeks. No resident was harmed as a result of the deficient practice. 3. The CFO or designee in-serviced business office staff on Resident	3/11/2022 5/6/2022 3/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 568	Continued From page 3 funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure resident funds were not commingled with the funds of any other person other than another resident. The facility census was 45. (Identifiers for Non-Residents'- TF1, TF2 and TF3) The findings included: Review of the facility's trial balance report dated 2/18/22 showed a total of 18 resident accounts. When the writer reconciled the trial balance report with the facility census report dated 2/17/22, it was revealed that three (3) of 18 (TF1, TF2, and TF3) accounts listed on the trail balance report did not belong to residents that reside in the skilled nursing facility. Review of the Facility's Assisted Living Census/Resident Roster showed that TF1 and TF2 were listed as residents of the Assistant Living ; and TF3 was a resident of the facility's Memory Care Unit. During a face-to-face interview on 02/22/22 at 2:30 PM, Employee #19, (Chief Financial Officer) reviewed the documents and stated that the names [TF1, TF2, and TF3] and accounts listed on the trial balance report were not residents of the skilled nursing facility.	F 568	Deposit Fund Policy specifically in maintaining a system that assures a full and complete and separate accounting practice. The CFO or designee will monitor for compliance by auditing Trial Balance statements monthly for the next 3 quarters. 4. Performance will be monitored, and compliance reported quarterly to the QAPI committee by the CFO or designee.	On-going
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v)	F 569		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 4 §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure that one (1) resident's funds were conveyed within 30 days of their death. The facility census was 45. (Resident #289) The findings included: Review of the facility's trial balance dated 02/18/22 showed a total of 18 resident accounts. Review of the trial balance report showed that Resident #289 had a "resident funds" account with a balance of $1659.69. The status of the account was recorded as "frozen" as of 01/19/22.	F 569	1. Resident #289 funds were conveyed on 2/24/2022 and account closed. 2. Accounting records of discharged or deceased residents for the past year were reviewed by the CFO and no other resident records identified as being deficient. 3. The business office staff were in-serviced on Resident Deposit Fund Policy concerning the proper procedure for conveying funds within 30 days upon discharged, eviction, or death. The CFO or designee will monitor compliance monthly for the next 3 quarters and will record the residents name, date of discharge/eviction/death, balance funds in the resident Trust Account, and disposition of funds including any documentation of said disposition on audit tool. 4. Performance will be monitored, and compliance reported quarterly to the QAPI committee by the CFO or designee.	2/25/2022 2/26/2022 3/11/2022 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 5 According to the Death in Facility Tracking Record, Minimum Data Set dated 01/15/22 showed that Resident #289 was coded as follows: Section A2000 (Discharge Date) was recorded as 01/15/22; and Under Section A2100 Discharge Status the resident was coded as "deceased". During a face-to-face interview on 02/22/22 at approximately 4:30 PM, Employee #19, (Chief Financial Officer) stated, "The accountant (facility staff) believed Social Security would take back the January [2022] Social Security Administration payment due to death so she is waiting. We will try to close the account this week." The facility's staff failed to convey Resident #289's funds within 30 days of death to her responsible party or probate jurisdiction administering the resident's estate.	F 569		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 678	1. Advance Directives for the involved residents (#20, #37, #38) were reviewed with residents and family, and their health records have been updated to reflect their wishes. 2. A review of all residents advance directives was conducted by the Social Services Director to identify 8 residents without advance directives. The advance directives for those residents(8) identified was reviewed with residents and family and their health records updated to reflect their wishes 3. Social Service Director or designee have been in-serviced to ensure that all residents are offered the opportunity to	2/22/2022 2/25/2022 2/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews for three (3) of 32 sampled residents, facility staff failed to offer residents or their representatives an opportunity to formulate an Advance Directive. (Residents' #20, #37 and #38). The findings included: 1.Resident #20 was admitted to the facility on 10/26/21 with multiple diagnoses including Parkinson's Disease, Alzheimer's Disease, and	F 578	formulate their advance directives, obtain order from the attending Physician, review code status with family and residents, and update resident's health record to reflect their code status wishes. o Social Service Director or designee will monitor for compliance on a monthly basis to ensure compliance and report findings to the DON and Administrator 4. Social Service Director or designee will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 7 Non-Alzheimer's Dementia. Review of the Quarterly Minimum Data Set dated 12/16/21 showed in Section C (Cognitive Patterns) Resident #20 had a Brief Interview for Mental Status (BIMS) summary score of "06," indicating severely impaired cognition. Review of Resident #20 's medical record revealed: 10/26/21 [physician's order] instructed, "CPR" (Cardiopulmonary Resuscitation). 11/04/21 [care plan] showed the following: -" Focus Area: Code status showed, "Full Code." - Goal: All staff will remain aware of [resident's name] wishes regarding code status and will ensure proper documentation. - Interventions included: Clarify [resident's name] code status upon admission; Inform MD (medical doctor) of [resident's name] wishes and obtain corresponding order, and review code status wishes with resident and RR (resident representative) as needed and at quarterly care plan meetings." 12/10/21 [Psychosocial Progress Note] documented "...Resident continues to have Full Code status- CPR..." During a face-to-face interview on 02/22/22 at 4:13 PM, Employee #14 (Director of Social Work) acknowledged that Resident #20 did not have an Advance Directive and stated, " It was discussed with her [Resident #20] representative.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8 It is documented in the progress notes." Resident #20's medical record lacked documented evidence that the facility's staff offered the resident or her representative an opportunity to formulate an Advanced Directive. 2. Resident #37 was admitted to the facility on 01/24/22 with the following diagnoses Congestive Heart Failure, Atrial Fibrillation or Other Dysrhythmia, Atherosclerosis, Hypoxemia, Essential Hypertension, and Diabetes Mellitus Type 2. Review of the Admission Minimum Data Set dated 01/31/22 showed in Section C (Cognitive Patterns) that the Resident #37 had a Brief Interview for Mental Status (BIMS) summary score of "12," indicating mildly impaired cognition. Review of the resident's medical record showed the following: 01/31/22 [physician order] instructed "CPR." (Cardiopulmonary Resuscitation). 02/02/22 [care plan] revealed the following: - "Focus Area: Code status showed "CPR." - Goal: All staff will remain aware of Resident #37 's wishes regarding code status and will ensure proper documentation. - Interventions included: Clarify [resident's name] code status upon admission; Inform MD (medical doctor) of [resident's name] wishes and obtain corresponding order, and review code status wishes with [resident's name and RR (resident	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 9	F 578		

representative) as needed and at quarterly care plan meetings."

02/03/22 [Psychosocial Progress Note] documented,"... Current code status is 'CPR' - Full Code."

During a face-to-face interview on 02/22/22 at 4:13 PM, Employee #14 acknowledged that Resident #37 did not have an Advance Directive and she stated, " I had a conversation with him and his son. It is documented in the progress notes."

Resident #37's medical record including progress notes lacked documented evidence that the facility's staff offered the resident or their representative an opportunity to formulate an Advanced Directive.

3. Resident #38 was admitted to the facility on 01/28/22 with the following diagnoses: Myasthenia Gravis Without (Acute) Exacerbation, Chronic Obstructive Pulmonary Disease (COPD), Deep Venous Thrombosis (DVT), Hypertension, Benign Prostatic Hyperplasia (BPH), and Non-Alzheimer's Dementia.

Review of the Admission Minimum Data Set dated 02/04/22 showed in Section C (Cognitive Patterns) Resident #38 had a Brief Interview for Mental Status (BIMS) summary score of "14" indicating intact cognition.

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

02/09/22 [physician order] instructed, "DNR" (Do Not Resuscitate).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 10 02/10/22 [care plan] showed the following: - "Focus Area: Code status showed "DNR." - Goal: All staff will remain aware of the resident's wishes regarding code status and will ensure proper documentation. - Interventions included: Clarify [resident's name] code status upon admission; Inform MD (medical doctor) of resident's wishes and obtain corresponding order, and review code status wishes with [resident's name] and RR (resident representative) as needed and at quarterly care plan meetings." 02/03/22 [Psychosocial Progress Note] documented "...Resident has DNR code status." Resident #38's medical record lacked documented evidence that the facility's staff offered the resident an opportunity to formulate an Advanced Directive. During a face-to-face interview on 02/22/22 at 4:13 PM, Employee #14 (Director of Social Work) acknowledged that Resident #38 did not have an Advance Directive and she stated, " I discussed it with him during his care conference. He said he wants to have a DNR code status."	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580	1. Resident #19 did not experience any adverse effect from this deficient practice, no additional intervention is necessary currently. The ADON informed the daughter on 1/19/2022 of the bruise.	2/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580	2. A review of all incident report for the last 30 days was conducted by Nursing Leadership to ensure notification of changes in resident's condition was communicated to family and attending Physician. No other findings were noted. 3. • Charge Nurses and Nursing Supervisors have been in-serviced to ensure that resident's representative is promptly notified of all changes in resident's conditions. • Nursing leadership team will monitor for compliance on a weekly basis to ensure compliance. • The results of the monitoring will be reported to the Director of Nursingimmediately. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/28/2022 2/28/2022 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

§483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and family interview, the facility's staff failed to inform a resident's family member about the resident's change in status (bruise to right brow) for one (1) of 32 sampled residents. (Resident #19)

The findings included:

Review of a policy titled, "Accident /Incident" instructed staff to, "report the accident/incident to his/her immediate supervisor as soon as practicable ..."

During a face-to-face interview on 02/17/22 at approximately 11:30 AM, Resident #19's daughter (responsible party) stated that when she visited her mother in January (2022), she observed her mother with a left black eye and swollen area on her forehead on the same side. However, no one from the facility made her aware. When she asked staff about her mother's injuries, they informed her that her mother hit her face on the side rail during the night.

Resident #19 was admitted to the facility on 09/17/19. The resident had multiple diagnoses including Muscle Weakness, Repeat Falls, and Insomnia.

Review of an incident progress note dated 01/19/22 at 16:55 (4:55 PM) showed, "resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13 ...reported an unwitnessed fall to her daughter ...upon assessment a swollen area was noted on the left eye brow and right occipital area ...resident alert and verbally responsive, neuro(logical) checks were WNL (within normal limits). Resident denies any pain ...MD (medical doctor) notified new orders received ...send resident to the ER (emergency room) for CT(computer tomography)/head and further evaluation ...resident's daughter refused for resident to be taken to the ER, she stated she thought a CT could be done at the bedside ..." Review of the facility's investigative report revealed the following written statements: 01/20/22 - Employee # 3 (certified nurse aide) documented, "On 1/19/22 at approximately 12:40 AM, I was making rounds down the hallway ...I heard [resident's name] yelling ...help, help, help ...I immediately ... ran into room 146. She was holding the left side rail tightly, her feet were tangled up in the sheets ...she was hitting her head on the side rail ...I stood in front of the side rail to protect her from falling, I then yelled for help ..." 01/20/22 - Employee # 4 (certified nurse aide) documented, "On 1/19/22 at approximately 12:40AM, I was standing in the nurses station ... when I heard [Employee #3's name] yelled help ...I immediately went to room and saw [resident's name] with her feet entangled ...she was moving her head up and down striking the side rail on the left side ... [resident's name] was restless that night and I sat with her until she fell asleep ..." Review of a Quarterly Minimum Data Set dated 12/15/21 revealed the following:	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14 In section C (Brief Interview for Mental Status) the resident had a summary score of "15" indicating the resident was cognitively intact. In section G (Functional Status) - Resident #19 was coded as requiring extensive physical assistance of two people with bed mobility. In section I (Active Diagnoses) - the resident was coded for Muscle Weakness, Repeat Falls, and Insomnia. Review of Resident #19's care plans showed the following: Focus area- Resident has an ADL (activities of daily living) self-care performance deficit (revision date 01/19/22). Interventions included bed mobility: the resident uses side rail enabler to maximize independence with turning and repositioning and transfer: the resident uses the side rail enabler for positioning and bed mobility. Focus area - [Resident's name] has an ADL self-care performance deficit ... (revision date 01/19/22). Interventions included bed mobility: [resident's name] is totally dependent on two nursing staff for repositioning and turning in bed every two hours and as necessary. Focus area- unwitnessed reported fall with minor injury (swelling) to the left eyebrow and right occipital area (revision date 01/19/22).	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 680	Continued From page 15 Interventions included transfer resident to ER for CT/head and further evaluation, apply ice pack to left eyebrow and right occipital swelling and Melatonin [increased] from 3 mg (milligrams) to 6 mg [for insomnia]. During a face-to-face interview on 02/25/22 at approximately 2:00 PM, Employee #2 (Director of Nursing) stated that the facility's staff did not make the family aware of the resident's change in status (swelling to left brow and right occipital area) because the certified nurse aides failed to inform the nurse (immediate supervisor) that Resident #19 hit her head on the side rail.	F 680		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and 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 three (3) of 32 sampled residents, facility staff failed to implement its written policy and procedure to investigate injuries of unknown source. (Residents' #4, #11 and #189) The findings included:	F 607	1. All staff who worked the previous day were required to submit statements regarding the incident for resident #4, #11 and #189. Statements were collected from all staff involved. Last statement collected on 2/25/2022. 2. A review of all incident reports for the previous 30 days was conducted to determine if appropriate investigation was implemented during such incident. No other resident was identified. 3. • Charge Nurses and Nursing Supervisors, CNAs have been in-serviced on the process collecting witness statements at the time of incident and if necessary staff working staff working on the previous shift. • Nursing leadership team will monitor for compliance on a weekly basis to ensure compliance.	2/25/2022 2/28/2022 2/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 16 Review of the facility's document provided to the surveyor on 02/23/22 entitled, "Reporting Incident Process" revealed: " ... Reportable Incidents/accidents include, but not limited to ... injuries of unknown origin ... pressure injuries, skin tears ...Investigation: Interview all staff working at the time, or if necessary, staff working previous shifts, of incident and collect written witness statements from all staff ..." 1. Resident #4 was admitted to the facility on 08/14/20 with multiple diagnoses that included: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Peripheral Vascular Disease and Muscle Weakness. Review of the medical record revealed the following: Quarterly Minimum Data Set (MDS) dated 05/14/21, facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "12", indicating moderately impaired cognition. 06/25/2021 at 6:42 PM [eInteract Change in Condition Evaluation]- " ... Situation ... skin discoloration ... assessment ... right upper arm measuring 5.5cm (centimeters) x7.5cm, skin remains intact, no c/o (complaint of) pain ..." Progress Notes: 08/25/21 at 8:23 PM (Incident Note) "At around 7pm when writer went to resident to administer his medications , noted resident with skin	F 607	• The results of the monitoring will be reported to the Director of Nursing. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee	On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 17 discoloration on his right upper arm, resident alert and verbally responsive ,upon interviewing resident verbalized "I do not know how it happened", upon assessment denies any pain ,appears reddish in color, skin intact measuring 5.5cm x 7.5cm, MD (medical doctor) made aware order given to monitor and report changes, RP (responsible party) made aware ..." 06/25/21 at 8:57 PM (Change in Condition Note) " ...At around 7pm when writer went to resident to administer his medications, noted resident with skin discoloration on his right upper arm, resident alert and verbally responsive ,upon interviewing resident verbalized "I do not know how it happened", upon assessment denies any pain, appears reddish in color, skin intact measuring 5.5cm x 7.5cm ... Recommendations (sp): MD made aware order given to monitor and report changes, RP made aware." Review of the facility's investigation documents revealed that facility staff failed to collect statements from all staff that were working on the shift when the incident occurred and staff working the previous shifts. 2.Resident #11 was admitted to the facility on 07/09/20 with multiple diagnoses that included: Parkinson's Disease, Muscle Weakness, Need for Assistance with Personal Care, and Dementia. Review of the medical record revealed the following: 06/02/21 [Annual MDS] - facility staff coded a BIMS summary score of "15", indicating intact cognitive response.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 18 06/19/21 at 11:58 AM [eInteract Change In Condition Evaluation]: "Situation ... skin wound or ulcer ...sacrum measuring 0.5 cm x 0.6 cm x 0.0 cm ... Resident sacrum area reassessed, stage 2 open area noted on sacrum ... no swelling, bleeding/discharge noted, deny any pain.MD/wound team aware." Progress Notes: 06/19/21 at 11:41 AM (Skin/Wound Note) "Resident sacrum area reassessed, stage 2 open area noted on sacrum measuring 0.5 cm x0.5 cm x0.0 cm. no swelling, bleeding/discharge noted, deny any pain. MD/wound team aware. New order to clean area with NS (normal saline), pat dry, apply bacitracin bid and cover with Xerofoam (a Vaseline impregnated cloth for wound care), until wound team assess. Spouse aware, RP (representative) ... made aware." 06/19/21 at 1:10 PM (Change In Condition Note) "Situation: Resident noted with sacrum skin tear Background: During ADLS (activities of daily living), assigned caregiver reported that resident has open sacral area. Assessment ... Resident sacrum area assessed, stage 2 open area noted on sacrum... Recommendations (sp): New order to clean open area with NS, pat dry, apply bacitracin bid and cover with Xerofoam, until wound team assess. Spouse aware, RP#2 also called ... made aware." Review of the facility's investigation documents revealed that facility staff failed to collect statements from all staff that were working on the shift when the incident occurred and staff working the previous shifts.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 19	F 607		

3.Resident #189 was admitted to the facility 10/27/2021 with diagnoses that included: Muscle Weakness, Difficulty Walking, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, and Anemia.

Review of the medical record revealed the following:

Admission MDS dated 11/03/21, facility staff coded a BIMS summary score of "15", indicating intact cognitive response.

Progress Notes:

01/11/22 at 4:15 PM (Health Status Note) "Resident complaining of pain on the right leg this afternoon, went to give the Tylenol (pain reliever) as schedule for 2pm , she refused, stated writer should call the husband. Daughter later visited and she calm down."

01/13/22 at 10:31 AM (Incident Note) " ... complaint of pain on the right leg on 1/11/22, she was able to move extremities within normal limits, she was on scheduled Tylenol extra strength 1000 mg every 8 hours. Per nursing documentation she refused 2 pm dose of Tylenol on 1/11/22 ... NP (Nurse Practitioner) assessed resident with resident's husband at bedside ... NP ordered ... an x-ray of the left hip for pain. X-ray results revealed mild disruption of the cortex of in left acetabulum compatible with minimally displaced fracture of left acetabulum and a CT (computed tomography) of left acetabulum recommended. Also revealed on the x-ray is mild osteopenia, and mild osteoarthritis. MD (medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 20 doctor) reviewed x-ray results and ordered a CT of the left hip (acetabulum) ... Resident and resident representative were notified of plan of care at bedside by the MD." Radiology Results Report: 01/13/22 at 3:41 AM (Left Hip X-ray) " ...Impression: 1. Mild disruption of cortex in left acetabulum compatible with minimally displaced fracture of left acetabulum ... Follow up CT with attention to left acetabulum ... Mild osteopenia. Mild osteoarthritis ..." 01/19/22 at 11:51 AM (CT scan) " ...Impression: Nondisplaced fracture of the left femoral greater trochanter is presumably on a pathologic basis ..." Review of the facility's investigation documents revealed that facility staff failed to collect statements from all staff that were working on the shift when the incident occurred. During a face-to-face interview on 02/23/22 at 11:00 AM, Employee #2 (Director of Nursing), was asked about the facility's incident investigation process. Employee #2 stated, "We collect statements and interview all the nurses, CNA's (Certified Nurse Aides), any other person on shift could have knowledge of the incident and the resident if applicable. When asked about statements from staff from the previous shifts, Employee #2 said, "We don't do retrospective interviews to get statements. We should but it's not something we do as part of the investigation process."	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609	1. Resident #3 did not experience any adverse effect	2/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 21 §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 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 observations, record reviews, and staff interviews, for three (3) of 32 sampled residents facility staff failed to report to the State Agency: (1) a facility-reported-incident (FRI) involving a medication error for one (1) resident;(2) a FRI involving an injury of unknown origin for one resident; and (3) a FRI involving an accident(fall) within the required time frame of 24 hours for one	F 609	From this deficient practice. Involved staff was educated on the 24-hour chart check process and disciplinary action taken for not accurately reviewing orders. Resident #239 incident report was submitted timely to DC Health on 9/10/21 at 4.22pm. FR1 late submission for #20 on 4/28/2022. Retrospectively, corrective action can not be accomplished for the resident. 2.A review of all orders for previous 30 days was conducted, no additional findings were noted. The facility also reviews all previous incident report submitted during the last 30 days to determine if it was reported appropriately and timely. There were no additional findings. 3. Charge Nurses and Nursing Supervisors have been in-serviced on different types of incidents to be reported to DC Health • Charge Nurses and Nursing Supervisor have been in-serviced on the 24-hour chart check process to prevent orders from being missed. • Nursing leadership team will monitor for compliance on a weekly basis to ensure compliance. • The results of the monitoring will be reported to the Director of Nursing immediately. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/24/2022 2/28/2022 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4101 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 22 (1) resident. (Residents' #3, #20 and #239). The findings included: 1. The facility's staff failed to report a FRI involving a medication error to the State Agency for Resident #3. Resident #3 was admitted to the facility on 11/05/20 with multiple diagnoses including Major Depressive Disorder, Anxiety, Post-Traumatic Stress Disorder, and Psychosis. During multiple observations from 02/17/22 to 02/25/22 starting at approximately 11:00 AM to approximately 5:00 PM, Resident #3 was noted in his room, well groomed, calm and cooperative with staff. Review of the medical record showed the following: 11/06/20 [physician order] instructed, "Depakote Delayed Release 500 mg (milligrams), give 1 tablet by mouth two times a day for mood disorder. The medication order had a discontinue date of 10/20/21. 11/18/21 [Lab result] - Valproic Acid (Depakote) result = 18 ug/ml [microgram/milliter](Reference range 50-100). Employee #8 (Nurse Supervisor/Registered Nurse) documented on the back of the lab result, "MD will review further on visit." 11/18/21 to 11/23/21 [nursing progress notes] lacked documented evidence that Resident #3 displayed behaviors such as yelling, screaming, crying, hallucination, delusion,	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 23 cursing, agitation, hitting, wandering, or pacing. 11/24/21 [nurse practitioner progress note] documented, "Valproic Acid level 18 (level range 50-100) on 11/18/21. It appears that medication was discontinued for unknown reason one month ago. Staff report pt (patient) remains combative and aggressive toward staff ...restart depakote, repeat level in Jan(uary)." 11/24/21 [physician order] instructed, "Start Depakote Delayed Release 500mg (milligram) BID (two-times-a-day) for mood disorder. Repeat Depakote level in January." 01/03/22 [Lab result] - Valproic Acid (Depakote) result = 40 ug/ml. MD made aware no new orders given. Review of electronic Medication Administration Records from 10/19/21 to 11/24/21 showed that the blocks (9:00 AM and 5:00 PM) for nurse initials were marked with an "X" indicating that the medication was discontinued by pharmacy. Review of the electronic Treatment Administration Records from 10/19/21 to 11/24/21 revealed that Resident #3 did not display behaviors such as yelling, screaming, crying, hallucination, delusion, cursing, agitation, hitting, wandering, or pacing. Review of Quarterly Minimum Data Set dated 08/10/21 revealed the following: In section C (Brief Interview for Mental Status) - was blank indicating the resident was severely cognitively impaired. In section E (Behavior) - Resident #3 was coded	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 24 for exhibiting physical behavior symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, or abusing others sexually) which occurred 1 to 3 days during the assessment period. The resident was also coded for Rejection of Care which occurred 1 to 3 days during the assessment period. In section I (Active Diagnoses)- the resident was coded for Dementia, Anxiety, Depression and Post-Traumatic Stress Disorder (PTSD). Review of Resident #3's care plans showed the following: Focus area- [Resident's name] has a mood problem r/t (related to) admission, with diagnosis of PTSD, major depression and anxiety revision date of 08/04/21. Interventions included Monitor/document/report PRN (as needed) any risk for harm to self ... Offer gentle words of support, concerns and encouragement to resident as needed. Focus area- The resident uses psychotropic medications r/t dementia with aggressive behavior. Interventions included monitor/record occurrence of the target behavior symptoms ...violence/aggression towards staff/others ...and document per facility protocol. During a face-to-face interview on 02/24/22 at 4:04 PM, Employee #8 (Nursing Supervisor/RN) stated that the pharmacy discontinued the medication (Depakote) in the electronic medication administration record. The employee	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 25 then said, "The resident was prescribed Depakote for mood disorder." During a face-to-face interview on 02/25/22 at 8:52 AM, Employee #2 (DON) stated that the medication error information was not sent to the Department of Health because her staff did not make her aware of the error. The employee then said that she would submit information about the medication error to the Department of Health. 2. The facility's staff failed to report a FRI involving an injury of unknown origin to the State Agency for Resident #20. Resident #20 was admitted to the facility on 10/26/21 with multiple diagnoses including Parkinson's Disease, Osteoporosis, Osteoarthritis, History of Hip Fracture, Alzheimer's Disease, Non-Alzheimer's Dementia, Orthostatic Hypotension, History of Falls with Multiple Injuries, Dislocation of Internal Right Hip Prosthesis and Depression. Review of a Quarterly Minimum Data Set (MDS) dated 12/16/21 showed that facility staff coded the resident in the following manner: In Section C (Cognitive Patterns)- Resident #20 had a Brief Interview for Mental Status (BIMS) summary score of "06" indicating severely cognitive impaired. In Section G (Functional Status)- the resident was coded for being totally dependent and requiring one person physical assist for bed mobility and dressing. Resident #20 was also coded for total dependence and requiring two or more persons for physical assistance with toilet use and	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 26 personal hygiene. In Section G0300 (Balance During Transitions and Walking)- the resident was coded as not being steady when moving from a seated to a standing position and transferring between bed, chair, or wheelchair. In Section G0400 (Functional Limitation in Range of Motion)- Resident #20 was coded for impairment on one side to the lower extremity (hip, ankle, foot). Resident #20 's medical record revealed the following: 12/03/21 [Physician's Telephone Order]: "Daughter- [Resident representative's name] will call the hospital to obtain follow up orthopedic return for mother and inform nursing." 12/03/21 [Physician's Telephone Order]: "F/u(follow-up) Appt (appointment) with [Orthopedic Physician's Name] on 12/06/21 @ (at) 9:30AM [Address and Telephone number of Orthopedic Physician's Office] one time only until 12/05/2021 23:59 (11:59 PM). Escort needed." 12/06/21 at 10:34 AM [Nursing Progress Note]: Incident Note- "Spoke with ortho (Orthopedic) doctor this morning; he stated that the resident's right hip was dislocated. Sending driver with RN (Registered Nurse) to take resident to the ER (emergency room) from the doctor's office." 12/06/21 at 10:34 AM [Nursing Administration Progress Note]- Incident Note: "Resident went out to F/U (follow-up) ortho appointment at 0900 (9:00 AM) with escort. Observed resident at	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 27	F 609		

nurses' station smiling, no c/o (complaint of) pain or discomfort prior to leaving. Had breakfast and left the facility in stable condition. Driver informed me that daughter met them at doctor's office. Daughter stated that the doctor told her the hip was dislocated and needed the driver to take a resident to the ER..."

Review of the facility's investigative report showed a progress/incident note dated 12/06/21, which documented a description of the incident. The investigative report also included four (4) written witnesses statements all of which were dated 12/06/21. However, Resident #20's medical record lacked documented evidence that the facility reported the FRI on 12/06/21 to the State Agency.

During a face-to-face interview on 02/25/22 at 2:50 PM, Employee #2 (DON) stated, "I did not report it to DOH (Department of Health). She (Resident #20) was not showing any signs of pain when she left our facility. I was present when she left. Her doctor called the facility and said her hip was dislocated. We had no x-ray at the time. I should have reported it (the incident) as an injury of unknown origin."

3. The facility's staff failed to report a FRI involving an accident (fall) within the required time frame of 24 hours to the State Agency for Resident #239.

Resident #239 was admitted to the facility on 01/14/20 with multiple diagnoses, including, Coronary Artery Disease, Cerebral Vascular Accident (CVA), Spastic Hemiplegia Affecting Unspecified Side, Seizure Disorder, Cataracts, Diabetes Mellitus Type 2, and Non-Alzheimer's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 28 Dementia. Review of a Quarterly Minimum Data Set (MDS) dated 10/05/21 showed that facility staff coded the resident in the following manner: In Section B 1000 (Vision) - the resident was coded as highly impaired to see with adequate lightly. In Section C (Cognitive Patterns)- Resident #239 had a Brief Interview for Mental Status (BIMS) summary score of "99" indicating that the resident was unable to complete the interview. In Section G (Functional Status)- the resident was coded for being totally dependent and requiring the physical assistance of one-person for locomotion on and off the unit, eating, and toileting. Resident #239 was also coded for being totally dependent and requiring the physical assistance of two or more persons for bed mobility, transfers, dressing, and personal hygiene. In Section G0300 (Balance During Transitions and Walking)- the resident was coded for not being steady when moving from a seated to a standing position and transferring between bed and chair or wheelchair. In Section G0400 (Functional Limitation In Range of Motion)- Resident #239 was coded as having an impairment of the upper and lower extremities. In Section G0600 (Mobility Devices) - the resident was coded as normally using a wheelchair. In Section H (Bowel and Bladder)- Resident #239	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 29 was coded as always incontinent for bowel and bladder. Review of the medical record revealed the following: 09/10/21 at 4:06 PM [Nursing Progress -Late Entry Note]: - Change in Condition Note: "Situation: Resident ['s] husband visited this afternoon, got resident out of bed and put her on the floor. Background: Resident transfers daily out of bed to w/c (wheelchair) with [manufacture's name] lift, 2-person assist. Assessment (RN)/Appearance (LPN): Observed lying on the floor, pillow under the head, POA (power-of-attorney) stated that he put her on the floor that she did not fall, Resident responsive but cannot tell what happen[ed], Nursing supervisor call and came to assess. Recommendations: [resident's physician] gave [an] order to send to ER, 911 called and came to [the] unit, but POA refused to transfer to ER, (911 reassess[ed] [the resident] and got [the] resident out of the floor to w/c per POA request." Review of the facility's investigative report dated 09/10/21 included the following: 1. A screenshot from the facility's Risk Management Department that described the incident the date and time of the incident documented as 09/10/21 at 4:25 PM. 2. Written statements from four (4) facility staff who worked on 09/10/21 and witnessed Resident #239 on the floor. All the previously mentioned witness statements were signed and dated on 09/10/21.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 30 3. A statement from Resident# 239's husband which documented: " ... an incident that did occur at [name of the facility] on Friday, 09/10/2021 at 1:45 PM in [resident's room number] ..." Review of the "Incident Investigation Report" form revealed that facility staff reported the allegation of an accident (fall) to the State Agency on 09/20/21 at 10:09 AM, which was ten days after the incident occurred. During a face-to-face interview on 02/24/22 at 3:49 PM, Employee # 5 (Charge Nurse/ Licensed Practical Nurse) stated, "It was me who observed the incident and reported it to the Assistant Director of Nursing. I was called to the room by the housekeeper and saw her (Resident #239) on the floor. The incident was documented in the progress notes, and I know we [the facility] reported it to Department of Health (State Agency)."	F 609		
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;	F 622	1. Resident #20 did not experience any adverse event from this deficient practice. Retrospectively, corrective action can not be accomplished for the resident as they have already returned to the facility. 2. A review of other residents determined there were no additional findings. Transfer and discharge requirement was immediately revised to include residents comprehensive care plan goals upon discovery while the surveyors were still in the Building. A Checklist was also developed. • Charge Nurses and Nursing Supervisors have been in-serviced on the revised transfer and	2/22/2022 2/22/2022 2/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 31 (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 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.	F 622	discharge requirement to include comprehensive care plan, face sheet, current physician orders, including medication, treatment order, transfer order, Advance Directives, H and P, Hospital Discharge summary, most recent lab and diagnostic, and transfer form. • Nursing leadership team will monitor all resident transfers for compliance on a weekly basis to ensure compliance. • The results of the monitoring will be reported to the Director of Nursing. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	On-going

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 32 (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- (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 one (1) of 32 sampled residents, facility staff failed to convey a resident's comprehensive care plan goals to the receiving provider during three (3) hospital transfers. (Resident #20)	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 33 The findings included: Resident #20 was admitted to the facility on 10/26/21 with multiple diagnoses including Parkinson's Disease, Osteoporosis, Osteoarthritis. History of hip fracture, Alzheimer's Disease, Non-Alzheimer's Dementia, History of Falls with Multiple Injuries, and Dislocation of Internal Right Hip Prosthesis. Review of the Quarterly Minimum Data Set (MDS) dated 12/16/21 showed the following: In Section C (Cognitive Patterns) - the resident had a Brief Interview for Mental Status (BIMS) summary score of "12," indicating mildly impaired cognition. In Section G (Functional Status)- Resident #20 was coded as being totally dependent and required the physical assistance of one-person for bed mobility and dressing. The resident was also coded a s totally dependent and requiring the physical assistance of two or more persons for toileting and personal hygiene. In Section G0300 (Balance During Transitions and Walking)- the resident was coded as not being not steady when moving from a seated to a standing position and transferring between bed, chair, or wheelchair. In Section G0400 (Functional Limitation in Range of Motion)- Resident #20 was coded as impairment on one side to the lower extremity. In Section G0600 (Mobility Devices) - the resident was coded as normally uses a wheelchair.	F 622		

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 34 Review of the Nursing Progress Notes from 11/28/21 to 12/20/21 showed that Resident #20 was transported to the Emergency Room on three different occasions, as evidenced below: 11/28/21 at 6:48 PM [Transfer to Hospital Summary]: "[physician's name] with orders to transfer pt (patient) to hospital, due to the right hip X-ray result." 12 /06/21 at 10:34 AM [Nursing Administration Progress Note]- Incident Note: "Resident went out to F/U (follow-up) ortho (orthopedic) appointment at 0900 (9:00 AM) with escort ...daughter met them at doctor's office. Daughter stated that the doctor told her the [resident's] hip was dislocated and needed the driver [of the facility's transportation company] to take the resident to the ER..." 12/21/21 at 12:50 PM [Transfer to Hospital Summary] - "RN called 911 for resident to be transferred to hospital d/t (due to) concerns of right hip re-dislocation. TO (telephone orders) w/ (with) [physician name] ...." Resident #20's medical record including progress notes from 11/28/21 to 12/31/21 lacked evidence that the facility's staff sent the resident's comprehensive care plan when she was transferred to the hospital on 11/28/21, 12/06/21, or 12/21/21. During a face-to-face interview on 02/22/22 at 4:14 PM, Employee #8 (Nurse Supervisor) stated, "We don't have an actual checklist to document what we send to the hospital for the resident, but we often document what we sent in	F 622		

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
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 35 the progress notes." During a face-to-face interview on 02/22/22 at 4:14 PM, conducted with Employee #11(Assistant Director of Nursing) when asked if facility staff sends the resident's comprehensive care plan with the other documents to the receiving provider (hospital) during transfers, she responded. "No."	F 622		
F 641 SS=D	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, facility staff failed to ensure Minimum Data Set (MDS) was accurately coded for a resident's discharge status for one (1) of 32 sampled residents. (Resident #141) The findings included: Review of the Physician's orders showed the following: 11/23/21 at 3:00 PM - T.O. (Telephone order) ... "Resident may be discharge (sp) home when ready"; 11/24/21- "Discharge home." The Physician's Discharge Summary signed and dated by the physician on 11/24/21 for Resident #141 showed: "Admission date -11/19/21 Discharge date - 11/24/21. Final Diagnosis- Cerebrovascular Accident, Other Significant Diagnosis; Dementia, Hypertension, Glaucoma and Hyperlipidemia. Disposition- Discharge with approval; Destination - Home."	F 641	1. Resident #141 MDS assessment was modified to reflect accurate discharge disposition. 2. A review of all discharges in the last 30 days was conducted to determine if they are coded correctly, no other findings were recorded. 3. • The MDS Coordinator and Nurse Manager/Supervisor/Social Service Workers have been in-serviced to ensure MDS assessments are coded accurately to reflect resident's disposition at the time of discharge from the facility. • MDS Coordinator team will monitor for compliance on a weekly basis to ensure compliance. • The results of the monitoring will be reported to the Director of Nursing. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/22/2022 2/22/2022 2/25/2022 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 36 According to the Discharge Reporting Minimum Data Set dated 11/24/21 the resident was coded as being discharged assessment -return not anticipated from the facility under Section F (Entry/Discharge Reporting); Under Section A2100 Discharge Status the Resident was coded as being discharged to an acute hospital. During a face-to-face interview on 02/22/22 at 4:42 PM, Employee # 9 (MDS Coordinator) acknowledged the finding.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §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	F 655	1. Resident #139 health record was updated to include diagnosis of Macular Degeneration. 2. A review of all baseline care plan reports within the last 30 days was completed by the Nursing Leadership to determine if a baseline care plan was completed upon admission. All missing diagnosis were updated. 3. IDT have been in-serviced on the process of completing baseline care plan within 48 hours of admission to include focus, goal, intervention and reviewing diagnosis both history and current with resident/family • Medical Record personnel have been in-serviced to bring old records of previously admitted resident for review by the IDT upon admission • Nursing team will review baseline care plan with resident and family and will be given copy of their baseline care plan • Nursing leadership team including the supervisor will review hospital admissions within 48 hours and monitor the process to ensure compliance. • Any findings of non-compliance will be reported to the Director of Nursing	2/24/2022 2/25/2022 2/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 37 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. (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 observation, record review and staff interview for one (1) of 32 sampled residents, facility staff failed to develop a baseline care plan to include Residents low vision resulting from an active diagnosis of Macular degeneration within 48 hours of admission to the facility. (Resident #139) The findings included: Resident #139 was re-admitted to the facility on 02/16/22 with multiple diagnoses including Nonexudative Age Related Macular Degeneration Right Eye Stage Unspecified. During a face-to-face interview on 02/23/22 at 11:22 AM, Resident #139 stated "I have Macular	F 655	4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 38	F 655		

Degeneration. I can't hardly see. I'm afraid I'm going to knock my glass of water over."

Review of the Electronic Health Record (EHR) for Resident #139, who was re-admitted to the facility on 02/16/22 showed the resident had a diagnosis of Nonexudative Age-Related Macular Degeneration Right Eye Stage Unspecified listed on her face sheet, Medication Administrative Record, Treatment Administration Record and Comprehensive-Care Plans from previous stay at the facility (admitted on 06/16/21 and discharged on 09/22/21).

Review of the "Nursing Admission Screening/History" dated 02/16/22, documented, "Eyes ... PERRLA (pupils, equal, round and reactive to light and accommodation)... and adequate vision" were marked with a check sign indicating the admitting nurse assessed the resident's pupils.

Review of the Baseline Care Plan dated 02/16/22 listed the resident's of Nonexudative Age Related Macular Degeneration Right Eye. However, there was no evidence that the facility developed a person centered base line care plan that included instructions/interventions to address Resident #139's diagnosis.

During a face-to-face interview on 02/24/22 at 2:35 PM, Employee #11 (Assistant Director of Nursing) stated, "This resident was here before in June (2021) when they put her back in the system it re-populates, I checked on the discharge summary in February (2022) and that diagnosis was not there, yes she has Macular Degeneration."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 F 684 SS=D	Continued From page 39 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, and staff interviews for two (2) of 32 sampled residents, the facility's staff failed to: (1) assess one (1) resident for edema to her left arm; and (2) follow physician's order to spoon feed one (1) resident at all meals. (Residents' #39 and #139) The findings included: 1.The facility's staff failed to assess for edema that was present in Resident #139's left arm. Resident #139 was re-admitted to the facility on 02/16/22, with multiple diagnoses including Acute Kidney Failure, Muscle Weakness, and Chronic Obstructive Pulmonary Disease. Review of the Quarterly Minimum Data Set (MDS) dated 09/21/21 revealed the following: In section C (Cognitive Patterns) the resident had a Brief Interview for Mental Status (BIMS) summary score of "15" indicating intact cognition. In section G (Functional Status) G0110 Activities	F 684 F 684	1. Order was given by the attending physician to elevate resident #139 left arm. Resident #36 spoon feed order was discontinued post reassessment by the Registered Dietician. 2.There were no other residents identified like these residents on the unit to have the concerns documented by the state agency. CNA Point of Care was updated to reflect resident's current status. 3. Charge Nurses and Nursing Supervisors have been in-serviced on accurate assessment of residents and documentation. • CNA have been in-serviced on the use of Point of Care Kardex in PCC to identify resident needs such as appropriate positioning of swollen extremities and appropriate specialty feeding protocol. • Chart audits and direct observation will be conducted for residents with swollen extremities and residents with specialty feeding protocol by Charge Nurse or designee and will be reported to the Director of Nursing immediately. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/24/2022 2/24/2022 2/28/2022 On-going

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40 of Daily Living (ADL) Assistance, Bed Mobility facility staff coded "extensive assistance "and resident requires "one-person physical assist" Transfer, facility staff coded "extensive assistance" and resident requires "Two-person physical assist" Walk in room, facility staff coded "Activity did not occur" Toilet use, facility staff coded "Extensive assistance" and resident requires "Two-person physical assist" Personal Hygiene, facility staff coded "extensive assistance" and resident requires "Two-person physical assist" G0400 Functional limitation in range of motion, Upper extremity, facility staff coded "No impairment", Lower extremity is coded "Impairment on one side" Review of the nursing progress note dated 02/17/22 at 4:31 PM, revealed " ...resident has pitting edema in her bilateral lower extremities, and left arm, which [is] elevated on the pillows ..." Review of "Skilled Charting" notes from 02/17/22 through 02/23/22 lacked documented evidence that staff assessed resident's edema in her left arm. During multiple observation from 02/17/22 to 02/24/22 starting at at approximately 10:30 AM to 4:00 PM, the surveyor noted the resident lying in bed with the head of the bed elevated. The resident's left arm appeared larger that her right	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41 arm. Resident #139 stated, "My arm was swollen even worse when I was in hospital." During a face-to-face interview on 02/24/22 at 11:42 AM, Employee #11 (Assistant Director of Nursing) acknowledged the finding and stated "I spoke to the Nurse Practitioner yesterday (02/23/22) and we have been elevating the [resident's] arm." 2. The facility's staff failed to follow a physician order to spoon feed Resident #36 at all meals. Resident #36 was admitted to the facility on 11/22/19, with multiple diagnoses including Dysphagia, Oropharyngeal Phase, Unspecified Protein-Calorie Malnutrition, Abnormal Weight Loss, Unspecified Glaucoma, and Unspecified Dementia Without Behavioral Disturbance. During an observation of the second-floor resident dining area on 02/23/22 at 9:15 AM, Resident #36 was observed sitting at a table alone and feeding himself his breakfast. Review of Resident #36's medical record showed the following: 01/05/22 [physician order] directed, "Spoon feed at all meals" 01/21/22 [Quarterly Minimum Data Set] documented the following: In Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) the resident had a summary score of "03" indicating severe cognitive impairment.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42 In section G (Functional Status) facility staff coded the resident required "extensive assistance" and "one-person physical assist" with eating. In section I (Active Diagnoses)- the resident was coded for Non-Alzheimer's Dementia, Glaucoma, and Generalized Muscle Weakness. In Section K (Swallowing/Nutritional Status) Swallowing Disorder, facility staff coded "None of the above" indicating the resident did not display any sign/symptoms of possible swallowing disorder during this assessment period. The resident was also coded for receiving a "mechanically altered diet" while a resident. In section O (Special Treatments, Procedures, and Programs) - lacked documented evidence Resident #36 was receiving speech therapy services. Review of certified nurse aide check list titled; "Documentation Survey Report" dated from 02/01/22 to 02/23/22 recorded that Resident #36 was totally dependent on one-person (staff) physical assist for eating meals on multiple dates. During a face-to-face interview on 02/23/22 at 11:40 AM, Employee #11 (Assistant Director of Nursing) stated "I'm not sure what happened normally someone helps him (Resident #36) to eat."	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 43 §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 by: Based on observation, record review, and responsible party and staff interview, the facility's staff failed to ensure durable medical equipment (sling of a sit-to-stand mechanical lift) was in good working condition before transferring (to the commode) Resident #19, who subsequently had an assisted fall without injuries. The findings included: Resident #19 was admitted to the facility on 09/17/19. The resident had an history of multiple diagnoses including Muscle Weakness, Repeated Falls, Obesity, and Transient Ischemic Attack. The Department of Health (DOH) received the following updated incident report on 11/29/21: "During transfer to bathroom with 2 CNAs (certified nurse aide) with sit to stand lift during pm care, the sling hooked to the machine broke thereby causing resident to be lowered to the floor in a sitting position [on 11/26/21 at 9:30 PM]. The 2 CNAs called Charge Nurse and 2 other persons to assist resident off the floor after the head-to-toe assessment was conducted on the resident. Range of motion to resident's tolerance. [Resident's name] denied any pain at the time. Back in bed without any injuries noted CNAs educated to ensure the equipment and slings being used on resident are in good working order.	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44	F 689		

[Physician's name] and resident's daughter [Resident's daughter name] made area ...Update- every sling in the facility was checked for wear and tear: all slings with extensive wear and tear or questionable integrity of the sling handles; New slings were ordered and rec'd [received] manufacture's care instructions discussed and reviewed and laundry services; no further incidents identified with the use of slings."

During an observation on 02/17/22 at approximately 11:00 AM, Resident #19 was noted sitting in a wheelchair well-groomed, smiling, and talking with her daughter, who was in the room at the time of the observation.

Review of the nursing noted dated 11/26/21 at 23:20 (11:20 PM) showed the following:

"Situation: [Resident's name] had a witnessed fall in her bathroom.
Background: Diagnosis of Right Knee Osteoarthritis, Obesity, Muscle Wasting and Atrophy-Multiple Assessment (RN)/Appearance (LPN): Resident asked to use the toilet, 2 CNAs proceeded to use the standing [mechanical] lift for transfer resident from wheelchair to the toilet. Upon hooking up the sling to sit [Resident's name] on the commode, the sling broke from the sides, hence causing the resident to be lowered unto the floor. Fall is witnessed.
Recommendations: CNAs will use the ordered [Manufacture's name] lift for resident's transfer at all times. Check the [Manufacture's name] pad and equipment prior to use on resident. 2 person will continue with transfer at all times".

According to the facility's "Incident/Accident Investigation" completed by Employee #8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45 (Nursing Supervisor) on 11/26/21 and reviewed by Employee 1 (Administrator) and Employee #2 (DON) on 12/01/21. Per report, "Incident date - 11/26/21, Time- 9:30 PM, Location of Incident -resident's bathroom, Nature of Incident- Fall ...Resident assessment- vs (vital signs) 98.7 (temperature), 72 (pulse), 20 (respirations), 135/71 (blood pressure), 98% (pulse oxygen saturation rate). Head to toe assessment conducted- ROM (range-of-motion) to the resident's tolerance. Any significant changes noted in the last 24 hours to Incident - No. Interventions - new slings ordered." According to the written witness statement completed by Employee #27 (assigned CNA) on 11/26/21. Per the stated, "The standing [mechanical] lift pad malfunctioned while transferring resident onto the commode. Resident (Resident #19) was gently lowered to the (bathroom) floor." According to the written witness statement completed by Employee #26 (assisting CNA) on 11/26/21. Per the stated, "The standing [mechanical] lift pad malfunctioned while transferring resident onto the commode. Resident (Resident #19) was gently lowered to the (bathroom) floor." Review of Resident #19's medical record revealed the following: 10/08/21[physician's order] Instructed, "Transfer resident at all times with [Manufacture's name] lift with two persons assist due to general witness/lower extremities weakness. Significant Minimum Data Set dated 10/14/21	F 689		

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 46 revealed: In section C (Cognitive Patterns), Resident #19 had a Brief Interview for Mental Status summary score of "12", indicating the resident was moderately intact with cognition. In section G (Functional Status), Resident #19 coded as "extensive assistance" and requiring the physical assistance of two or people for toileting and "not steady only able to stabilize with staff assistance" with moving on and off toilet. The resident was also coded for using a device "mechanical lift" prior to current illness, exacerbation, or injury. In section I (Active Diagnoses) -Resident #19 was coded for Arthritis, Muscle Wasting, General Muscle Weakness, Personal History of Transient Ischemic Attack and Cerebral Infarction without Residual Deficit, and Obesity. Care Plans showed: Focus area- [Resident's name] has a self-care performance deficit r/t (related to) activity intolerance, fatigue, impaired balance (initiation date of 09/18/18). Interventions included: - [Resident's name] is totally dependent on two staff for transferring. - Nursing Rehab/Restorative - assist with all transfers ...when moving ...between surfaces or plans with or without devices. During a face-to-face interview on 02/17/22 at approximately 11:00 AM, Resident #19 answered to her name but failed to answer questions about fall on 11/26/21.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47 During a face-to-face interview on 02/17/22 at approximately 11:00 AM, Resident #19 daughter stated that a nurse made her aware that her mother had an assisted fall in the bathroom on 11/26/21. The resident's daughter said the strap on the [mechanical] lift broke, but my mother was fine she did not have any injuries. During a face-to-face interview on 02/25/22 at approximately 12:30 PM, Employee #28 (Supply Coordinator) stated that she observed the broken pad when she came in the next day after the resident's fall. She noted that the straps had broken away from the pad. The employee said that the straps were very dry and brittle. Employee #28 then stated that she had researched and found out that drying the pad in the dry will make the straps brittle. Additionally, the employee said, "We now air dry all pads, and we ordered new pads." Past Non-compliance Information During a face-to-face interview on 02/25/22 at approximately 2:00 PM, Employee #2 (DON) indicated the following interventions were implemented to address the deficient practice: o Resident #19 had a head-to-toe assessment conducted by nursing staff on 11/26/21. o The resident was assisted off the floor by four (4) staff members and placed in bed. o All [mechanical] lift pads were assessed, and the ones that appeared not to be in good repair were thrown away. o All residents who used the [mechanical] lift sizes were re-assessed to ensure staff was using the right size pad.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 48 o Nursing staff was in-serviced on assessing the pad and straps for safety before use. o Laundry staff was on how to launder pads properly. o Supply coordinator checks all pads monthely and documenting finding on an audit tool and makes DON and Administrator aware of any concerns with pads. o No other residents were affected by this deficient practice. The previously mentioned interventions were implemented before the State Agency's on-site visit of 02/17/22.	F 689		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, the physician failed to review the resident's complete health record to include	F 711	1. Resident #139 diagnosis was updated to include Macular Degeneration; ophthalmology consult was ordered. 2. Review of residents with similar diagnosis was conducted to determine if any other residents will be affected, there was no other resident affected. 3. The attending Physician was in-serviced on how to address all listed diagnosis when addressing history and Physical. Nursing supervisor/Charge Nurses was also in-serviced on how to address all resident diagnosis on admission. The MDS coordinator will review diagnosis list upon admission. Any findings of non-compliance will be reported to the Director of Nursing immediately. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/25/2022 2/25/2022 2/25/2022 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 49	F 711		

residents' diagnosis of Macular Degeneration for one (1) of 32 sampled residents. (Resident #139)

The findings included:

Resident #139 was re-admitted to the facility on 02/16/22, with multiple diagnoses including Nonexudative Age Related Macular Degeneration Right Eye Stage Unspecified.

During a face-to-face interview conducted on 02/23/22 at 11:22 AM, Resident #139 stated "I have Macular Degeneration I can't hardly see. I'm afraid I'm going to knock my glass of water over."

Review of the Electronic Health Record (EHR) for Resident #139, who was re-admitted to the facility on 02/16/22 showed the resident had a diagnosis of Nonexudative Age-Related Macular Degeneration Right Eye Stage Unspecified listed on her face sheet, Medication Administrative Record, Treatment Administration Record and Comprehensive-Care Plans from previous stay at the facility (admitted on 06/16/21 and discharged on 09/22/21).

Review of the "History and Physical Exam Form" signed by [physician's name] on 02/17/22, lacked documented evidence Resident #139's diagnosis of Nonexudative Age Related Macular Degeneration Right Eye Stage Unspecified. On the eye/vision exam section of the previously mentioned document the word "clear" was hand-written in that section.

During a telephone interview on 02/25/22 at 9:55 AM, Employee #12 (physician) stated, "Her (Resident #139) eyes were clear. Macular Degeneration is a diagnosis that's made in an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 50 Ophthalmologist's office." There was no evidence that Employee #12 (physician) addressed the resident's vision status in the total plan of care reviewed on 02/17/22.	F 711		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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 observation and staff interview during a tour of one (1) of two (2) medication storage rooms, facility staff failed to ensure that three (3)	F 761	1. The medication was immediately discarded, no resident was affected by this deficient practice. 2. The DON pulled all medications requiring date and refrigeration to determine if there are any expired or undated medications, no other findings was noted. 3. Charge Nurses and Nursing Supervisors have been in-serviced to ensure that all medications requiring date and refrigeration are done accurately. Audit tool created for monitoring compliance. 4. Nursing leadership team will monitor for compliance on a weekly basis to ensure compliance. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/17/2022 2/17/2022 2/17/2022 On-going

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 51 of three (3) insulin vials were dated when first opened. The findings included... According to the manufacture's storage instructions, "The Lantus vials you are using should be thrown away after 28 days, even if it still has insulin left in it." https://www.lantus.com/how-to-use/how-to-inject According to the manufacture's storage instructions, "Recommended storage conditions for NovoLog Insulin is 28 days after first use." https://www.novonordiskmedical.com/our-products/storage-and-stability.html On 02/17/22 at approximately 2:40 PM in the presence of Employee # 16 (Nurse Supervisor) an observation of the first floor medication refrigerator was conducted and the following was noted: Two (2) of 2 vials of Lantus Insulin 100 units were observed open with no date recorded (written) on the vial or the holding/outer container to indicate the first date it was open for use. One (1) of 1 vial of Novolog Insulin was observed opened with no date recorded (written) on the vial or the holding/outer container to indicate the first date it was open for use. At the time of the observation Employee # 16 stated the vials should have been dated when opened and acknowledged the findings.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents 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 observations and staff interview, facility staff failed to prepare and serve foods under sanitary conditions as evidenced by four (4) of four (4) damaged cutting boards, one (1) of one (1) soiled salamander grill, one (1) of one (1) fire extinguisher that was past due its yearly inspection date, four (4) of eight (8) soiled fire suppression nozzles, one (1) of three (3) dishwashing machines that leaked from the bottom when used, and one (1) of three (3) dishwashing machine that did not consistently reach a minimum final rinse temperature of 160 degrees Fahrenheit. The findings included:	F 812	1.All damaged cutting boards were discarded immediately and replaced with brand new boards. Grill and nozzles were degreased immediately, Kitchen fire extinguisher was immediately replaced, and dish cart was relocated from that area, second- floor pantry dishwashing machine was immediately placed out of service. Dish repair vendor repaired second- floor pantry dishwashing machine. Sanitation cycle time was increased to help reach appropriate temperature on kitchen dish washer. 2.The Dining Services Department inspected all cutting boards, grill, nozzles, and equipment. No other deficiencies were identified. Second floor dishwashing machine is operable. Main kitchen dishwasher service for preventive maintenance is scheduled for March 22, 2022. 3.The Director of Dining Services and Chef conducted an in-service to dining staff on proper cleaning of appliances, the avoidance of blocking the kitchen fire extinguishers, on dishwashing and sanitizing process and reporting any defective equipment to the maintenance department. The Dining Service Management team has added cutting board inspection to the weekly audit list on February 17, 2022. Cutting boards will be automatically replaced every three months to prevent deep grooves. Beginning March 17, 2022 the Director of Dining Services or designee will do an additional random audit weekly for four weeks and then monthly to ensure compliance. A checklist was created to inspect the grill and nozzles after each shift and an on- going audit will be conducted once a week by the Director of Dining Services or designee.	2/25/2022 2/25/2022 2/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 53 During a walkthrough of dietary services on February 17, 2022, at approximately 10:30 AM and on February 24, 2022, at approximately 9:45 AM, the following were observed: 1. Two (2) of two (2) red cutting boards and one (1) of one (1) white cutting board that were stored for use, and one (1) of one (1) green cutting board that was being used to slice carrots were damaged with deep grooves that could possibly inhibit bacteria and odor. 2. One (1) of One (1) salamander grill was soiled with grease deposits on the outside. 3. One (1) of two (2) fire extinguishers in the main kitchen had not been inspected since November 2020. 4. Four (4) of eight (8) fire suppression nozzles located above the grease fryer and the flat grill were soiled with grease deposits. 5. One (1) of one (1) dishwashing machine located on the second-floor pantry leaked from the bottom when used. 6. One (1) of one (1) dishwashing machine in the main kitchen failed to reach a minimum final rinse temperature of 180 degrees Fahrenheit on two (2) of three (3) observations. These observations were acknowledged by Employee #6 (Director of Food Services) during a face-to-face interview on February 25, 2022 at approximately 2:45 PM.	F 812	Fire extinguisher access and reporting any defective equipment were added to the daily checklist of the Director of Dining Services or designee. Temperature logs are conducted twice a day and daily audits are done by the Director of Dining Services or designee. 4.Performance will be monitored, and compliance reported quarterly to the QAPI committee by The Director of Dining Services or designee.	On-going
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842	1. Resident #36 advance directives was immediately updated to reflect the DNR status.	2/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 54 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §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	F 842	2. Review of all residents advance directives was conducted by social services department, those found to be deficient are being addressed by the social work department. 3. Social Workers/Charge Nurses and Nursing Supervisors have been in-serviced to ensure that resident code status is updated timely to reflect their wishes. Social Worker team will monitor for compliance on a weekly basis to ensure compliance. The results of the monitoring will be reported to the Director of Nursing. 4. Performance will be monitored, and compliance reported quarterly to the QAPI committee by The Director of Dining Services or designee.	2/25/2022 2/25/2022 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 55 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening 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 reviews and staff interview, the facility staff failed to accurately document a resident's Advance Directive directions (wish) to be a Do Not Resuscitate (DNR) in the medical record one (1) of 32 sampled residents. (Resident #36) The findings include: Resident #36 was admitted to the facility on 11/22/19 with multiple diagnoses that included,	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 56 Dysphagia, Oropharyngeal Phase, Unspecified Protein-Calorie Malnutrition, Abnormal Weight Loss, Unspecified Glaucoma and Unspecified Dementia Without Behavioral Disturbance. Review of the Quarterly Minimum Data Set (MDS) dated on 01/21/22, the resident had a Brief Interview for Mental Status (BIMS) summary score of "03" indicating severe cognitive impairment. Review of the medical record revealed a document titled, "Advance Directives" signed and dated by Resident #36 and his Power-of-Attorney on 01/27/20. The Advance Directive form documented that the resident's code status as "No Code/Do Not Resuscitate". However, review of an active physician's order dated 11/25/19 directed, "CPR" (cardiopulmonary resuscitation). Also, review of Resident #36's comprehensive care plan showed a focus area of "[resident's name] Advance Directive Full Code/CPR" (date initiated 03/06/20). Interventions included to "Honor [resident's name] wishes to be a full code and resuscitate as necessary" (date initiated 03/06/20). Additionally, [psychosocial progress notes] documented the following: 10/08/21 at 7:55 AM - "He [Resident #36] has Full Code status ..." 02/02/22 at 12:15 PM - "He [Resident #36] has a Full Code status ..." During a face-to-face interview on 02/22/2022 at	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 57 4:30 PM, Employee #14 (Director of Social Work) stated, " It was input incorrectly, and it was brought to the attention of the DON (Director of Nursing)."	F 842		
F 880 SS=E	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. 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	F 880	1. There was no adverse effect to this deficient practice to resident #1, #2, #9, #17 and #239. The affected staff were immediately in serviced and redirected to practice appropriate infection control practice. 2/25/2022 2. The nursing leadership conducted infection control round on the unit to ensure that staff are practicing appropriate infection control protocol, while serving meals and during wound care, no other findings was observed. 2/18/2022 3. Employees have been in-service on infection control practices as it relates to hand hygiene. License Nurses were also in-serviced on infection control practice during wound care. Nursing leadership team will monitor for compliance on a weekly basis to ensure compliance. The results of the monitoring will be reported to the Director of Nursing. 2/28/2022 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee. On-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 58 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 (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, record review, and staff interviews, for five (5) of 32 sampled residents, the facility's staff failed to maintain Infection Control Practices to minimize or prevent the potential spread of infection as evidenced by: (1)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 59	F 880		

staff not performing hand hygiene before serving a lunch tray for one (1) resident; (2) staff not performing hand hygiene between care (hygiene) for two (2) residents; (3) staff not providing a barrier during wound care for 1 resident; and (4) not wearing clean gloves when changing bed linen for one (1) resident. (Residents' #1, #2, #9, #17, and #239).

The findings included:

1. The facility's staff failed to perform hand hygiene before serving Resident #9 her lunch tray.

Review of a policy titled, "Assisting the Impaired Resident with In Room Meals, instructed staff to, "wash their hands before serving food to residents ..."

Resident #9 was admitted to the facility on 06/11/18 with multiple diagnoses including Dementia without Behavioral Disturbances and Dysphagia.

During an observation on 02/18/22 starting at 12:30 PM, the following was observed:

-Employee #10 (Certified Nurse Aide) was observed walking in the dining room, not wearing gloves, and rubbing her hands on her uniform multiple times.

-The employee then collected Resident #9's lunch tray and placed it on the table in front of the resident.

-Employee #10 sat beside the resident, removed the plastic covering from the plastic spoon, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60 dipped the spoon in the cream spinach. -The employee then attempted to feed Resident #9 but was stopped by the surveyor. When asked if she washed her hands after touching her uniform multiple times, serving the resident lunch tray, opening the resident's feeding utensil, and dipping the spoon in the cream spinach? Employee #10 stated that she did not wash her hands, but she should have washed her hands or used hand sanitizer before serving the resident her lunch. Employee #10 discarded Resident #9's lunch tray and washed her hands. Review of physician order dated 10/06/21, instructed, "NAS (No Added Salt) diet pureed texture, thin consistency ..." Review of the Quarterly Minimum Data Set dated 12/07/21 revealed the following: In section C (Brief Interview for Mental Status) was blank indicating the resident was severely cognitively impaired. In section G (Functional Status) Resident #9 was coded as totally dependent on the physical assistance of one person for eating. In section I (Active Diagnoses)- the resident was coded for Dementia and Dysphagia Review of the resident's care plan showed the following: -Focus area - Nutrition [resident's name] is noted ...with care & comfort measures due to Advanced dementia per family request (revision date	F 880		

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
	095038	A. BUILDING _____ B. WING _____	C 02/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61 12/16/21). -Interventions included provide NAS (No Added Salt) Diet/Mech (mechanical) soft texture/thin liquids and spoon feed meals and snacks. During a face-to-face interview on 02/18/22 at approximately 12:00 PM, Employee #2 (Director of Nursing) stated that staff should wash their hands or use hand sanitizer before serving trays or feeding residents. 2. Facility staff failed to maintain infection control practices while assisting residents with care (hygiene) before a meal. A dining observation was performed on the 2nd floor dining area on 02/18/22 at 12:30 PM, the surveyor observed the following: -Facility's staff bringing residents into the common dining area and placing residents individually at separate tables. - Employee # 25 (Certified Nurse Aide) not wearing gloves and using a wipe to clean Resident #17 and Resident #1 face and hands. - However, the employee failed to sanitize her hands before and between providing care to the previously mentioned residents. During a face-to-face interview conducted at the time of observation, Employee # 25 (Certified Nurse Aide) stated "We sanitize all the residents before they eat". The employee said that she should have sanitized her hands before and between providing care to the residents.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62 3. The facility's staff failed to maintain Infection Control Practices when providing wound care for Resident #2. Resident #2 was admitted to the facility on 12/06/18. The resident had history of multiple diagnoses including Hemiplegia and Hemiparesis, CVA Dementia, Urinary/Fecal Incontinence, and Stage 4 Right Ischium Pressure Injury. During an observation on 02/25/22 at approximately 1:00 PM, Employee #11 (Assistant Director of Nursing/ Wound Nurse) provided wound care for Resident #2's Stage 4 right ischium pressure injury. While providing wound care, Employee #11 failed to maintain Infection Control Practices by not placing a barrier under the resident. Instead, the employee provided wound care on top of Resident #2's urine-soiled incontinent brief. Review of the resident's medical record showed the following: 02/18/22 [physician's order] - "Cleanse right ischium with Dankin's Solution (antiseptic that kills most forms of bacteria and viruses), pat dry, apply Santyl ointment, then skin prep to peri wound, and cover with dry dressing every day." Review of the Wound-Weekly Observation Tool (Licensed Nurse) dated 02/24/22 documented the following: "Location- right ischium, inhouse-acquired on 05/13/21, type - pressure, pressure ulcer stage: original -Stage 2 , current - Stage 4, visible tissue: unchanged, unhealthy granulation tissue, and 100% necrotic tissue, drainage: type-serous, amount - scant, odor- none present,	F 880		

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 63 wound measurements: Length - 15 mm (millimeters), Width 14 mm, Depth- blank ... comments- seen by wound doctor. Bedside debridement done. Continue with POC (plan of care)." Review of the Quarterly Minimum Data Set dated 11/08/21 revealed the following: In section C (Brief Interview for Mental Status)- the resident was given a summary score of "5" indicating the resident was severely cognitively impaired. In section I (Active Diagnoses)- Resident #2 was coded for Hemiplegia and Hemiparesis. In section M (Skin Condition) - the resident was coded for having one Stage 4 pressure ulcer, using a pressure reducing bed and chair, ointments, and medication. Review of care plan showed the following: "Focus area- [Resident' s name] has a...pressure injury (right ischium) related to fragile skin [and] impaired mobility. Interventions included apply treatments per MD (medical doctor) order, follow facility protocols for treatment of injury, and report abnormalities ...to MD (medical doctor). " During a face-to-face interview on 02/25/22 at 1:30 PM, Employee #11 stated that she should have placed a barrier under the resident before providing wound care. 4. The facility's staff failed to wear clean gloves when changing Resident #239's bed linen.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 64 Resident #239 was admitted to the facility on 01/14/20 with the following diagnoses Cerebral Vascular Accident (CVA), Spastic Hemiplegia Affecting Unspecified Side, Cellulitis of Left Lower Limb, Non-Alzheimer's Dementia, and Stage 4 Pressure Ulcer of Right Buttock, Stage 4. Review of a Quarterly Minimum Data Set (MDS) dated 10/05/21 showed that facility staff coded the resident in the following manner: In Section C (Cognitive Patterns)- Resident #239 had a Brief Interview of Mental Status (BIMS) summary score of "99," indicating that the resident was unable to complete the interview. In Section G (Functional Status)- the resident was coded as being totally dependent and required the physical assist of two or more people or bed mobility, transferring, and dressing. In Section H (Bowel and Bladder)- Resident #230 was coded as always incontinent of bowel and bladder. During an observation on 02/24/22 at 12:30 PM, the following was observed: -Resident #239 was laying in her bed while Employee #21 (Certified Nurse Aide - CNA) and Employee #22 (CNA) were providing Activities of Daily Living (ADL) care including grooming, bathing, perineal care, and changing the resident's bed linen. - After bathing the resident and providing perineal care, Employee #21 did not change her gloves. Instead she picked up the bed clean linen to	F 880		

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
	095038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 65 make Resident #239's bed. - The surveyor then stopped Employee #21 and asked are you suppose to change your gloves? Employee #21 stated, "Oh, that's right." The employee then removed her gloves, washed her hands and left the room. In a few minutes, she returned with the clean bed linen. She then washed her hands, donned cleaned gloves and she continued to provide ADL care to the resident.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) high temperature dishwashing machine in the main kitchen that did not reach a minimum final rinse temperature of 180 degrees Fahrenheit on two (2) of three (3) observations, and one (1) of one (1) dishwashing machine in second floor kitchen that consistently leaked from the bottom when in use. The findings included: 1. One (1) of one (1) dishwashing machine in the main kitchen failed to reach a minimum of 180 degrees Fahrenheit on two (2) of three (3) observations on February 24, 2022, at approximately 9:45 AM.	F 908	1.Dishwashing vendors were called out and inspected and identified needed repairs for both the dishwashing machine in the main kitchen and the second-floor pantry dishwashing machine. The second-floor pantry dishwashing machine was repaired. The repair vendor ran several tests on the kitchen machine, confirmed that the final rinse reached 180 degrees Fahrenheit consistently. 2. The Director of Dining purchased plate thermometer stickers to ensure each plate reached 180 degrees Fahrenheit. Repair vendor scheduled for follow up parts and service on March 22, 2022. No resident was affected by deficient practice. 3.The Director of Dining in-serviced dining staff to inform maintenance immediately if they find any issues with any equipment. The Director of Maintenance or designee will monitor compliance monthly to ensure all kitchen equipment are working properly. 4. Performance will be monitored, and compliance reported quarterly to the QAPI committee by the Director of Maintenance or designee.	2/25/2022 2/25/2022 2/25/2022 On-going

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
	096038	A. BUILDING _____ B. WING _____	C 02/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 66 The contracting repair company (Hobart) came in and determined that one (1) of three (3) heater elements inside the machine was inoperative, but the machine was still able to reach a minimum final rinse temperature of 180 degrees Fahrenheit on most occasions. A replacement part was ordered, and the machine was used to clean and disinfect dishes along with a disinfectant solution from the three-compartment sink. 2. One (1) of one (1) dishwashing machine located on the second-floor pantry leaked from the bottom when used. These observations were acknowledged by Employee #6 (Director of Food Services) during a face-to-face interview on February 25, 2022, at approximately 2:45 PM.	F 908		